

HEARING ON PENDING HEALTH AND BENEFITS LEGISLATION

HEARING BEFORE THE COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE ONE HUNDRED THIRTEENTH CONGRESS FIRST SESSION

OCTOBER 30, 2013

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HEARING ON PENDING HEALTH AND BENEFITS LEGISLATION

WEDNESDAY, OCTOBER 30, 2013

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:04 p.m., in room 418, Russell Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders, Tester, Begich, Blumenthal, Hirono, Burr, Isakson, Johanns, and Heller.

OPENING STATEMENT OF HON. BERNARD SANDERS, CHAIRMAN, U.S. SENATOR FROM VERMONT

Chairman SANDERS. Good morning everyone. I will make an opening statement, Senator Burr will make an opening statement, and then we will hear from the Senators who have been so kind to join us today to talk about legislation that they are proposing.

Today's agenda, once again, reflects important work by Senators on both sides of the aisle and demonstrates the Committee's desire to be responsive to the concerns expressed by veterans and their families.

Before I discuss a few of the bills I have on today's agenda, I want to briefly touch on the issue of the Administration's views. Let me be kind of to the point on this one.

I understand that, as a result of the government shutdown and a lot of pressure on the VA, they have not gotten all of their comments and views in. We also understand that in the past they have not always been prompt in their responses to the legislation that we have proposed.

So, let me just say this to them. The job of this Committee and what we were elected to do is to represent the people of this country and, in particular, the veterans of this country. If the VA is not responsive in getting their comments in, that is fine. It is not going to impact us at all. We are going to go forward.

But clearly, the VA is going to have to implement the policies developed by this Committee and this Congress and we want to work with them. But our job is to legislate and we are going to go forward with or without the cooperation of the VA and the Administration.

Let me touch on some of the pieces of legislation that I will be talking about today and will be introducing. At the top of my list is the issue of expanding access to VA health care.

In my view—and I think VA does not get enough credit for this—VA is running a very high-quality, cost-effective health care system in this country. The media does not pick up on it and I think many Americans just do not understand what the VA does. But the fact is that veterans do understand that.

I can tell you that in Vermont, and I suspect in other facilities that I have seen, I have been very impressed by the kind of out-of-the-box work done by the VA, providing excellent quality care in a cost-effective way.

Is the VA perfect? When you run 152 hospitals and 900 CBOCs, believe me they have problems every single day but so does every other medical institution in America.

One of the goals that we are shooting for is to expand VA health care, understanding that the major function of the VA and their highest priority is to take care of those who are service-connected. That goes without saying. There is no debate about that. Men and women who have served this country and have been wounded are getting their care at the VA. That is the highest priority. We want to take care of indigent veterans as well.

I think we can expand what we are doing and bring more veterans into the system. While it may cost the VA more money, it will save money in terms of what we spend on health care in general because VA health care is cost-effective. That is issue number 1.

Issue number 2, where I think we need to make some changes is regarding dental care. Senator Burr and I both sit on the Health, Education, Labor, and Pensions Committee. We talk a lot about health care.

One of the issues that is not talked about a lot in this country is the crisis in dental care. It is a huge crisis. Millions of people have no insurance. Millions of adults are seeing their teeth rotting in their mouths which, by the way, leads to other types of health care problems.

We are introducing legislation which, for the first time, would allow veterans to get dental care other than service-connected. Right now if you are service-connected, you get good quality dental care. If you are not, you do not.

I was recently in Tuscaloosa, AL, talking to the dental people there, and the guy who is running their dental department was telling me that it breaks his heart that they have Purple Hearts walking in who cannot get dental care.

So, I think we have a crisis, and we are going to start with some pilot projects which I think will begin to address a very, very serious problem.

Another issue that we are going to address is sexual assault and domestic abuse. We know sexual assault occurs all too often in the military. Everybody here is aware of that. That is not acceptable.

According to DOD, an estimated 26,000 servicemembers experienced unwanted sexual contact in 2012; and we all understand, by the way, that it is not just women. Men are being sexually assaulted as well. This is an issue we are going to address.

We are also going to strengthen the SCRA. When men and women volunteer to serve in the Armed Forces, they should do so knowing Congress will do all it can to support their efforts.

Congress enacted the Servicemembers Civil Relief Act for just that reason, to enable servicemembers to devote their focus to the defense needs of this country. As I think Members of the Committee know, we took a close look at these protections at a hearing earlier this year and we learned that there was room for improvement, and that is why I introduced the SCRA Enhancement and Improvement Act of 2013.

Also, we have introduced legislation that addresses concerns of the *Independent Budget* of VSOs related to VA compensation for hearing loss and related injuries, life insurance for service-disabled veterans, and automobile grants for some of our most disabled veterans.

So, let me conclude by saying that we are trying very hard to run this Committee in a bipartisan way because I have no doubt that my Republican colleagues absolutely feel as strongly as my Democratic colleagues and I do on the issue of veterans, and I hope we have done that, and I want to continue to do that. And if I am not doing that, I want to hear from my Republican friends.

I think we are making progress and we have a long way to go. We look forward to that progress.

Now, Senator Burr, the mic is yours.

**STATEMENT OF HON. RICHARD BURR, RANKING MEMBER,
U.S. SENATOR FROM NORTH CAROLINA**

Senator BURR. Good afternoon, Mr. Chairman. We have spent most of the day together. It is appropriate that we would end the day together. And I welcome our gang of colleagues that are here to promote, I am sure, legislation that they are passionate about.

To start with, I want to offer a few observations about today's agenda. First of all, for many of the programs that these bills would change, the Committee has not yet had oversight hearings to examine what gaps in inefficiencies might exist.

Also, there are dozens of bills on the agenda, even though I do not think we can thoroughly cover but a handful of them at a legislative hearing like this; and we are, again, considering many bills that have significant cost but do not include suggestions how to pay for them. I am not saying anything new to the Chairman and hopefully I get an "A" for consistency.

So, it is my hope that, as we consider what bills should be advanced, the Committee will take steps to ensure that we have a clear understanding of how well existing programs are working, one; and what changes are truly needed and how much any changes would, in fact, cost. We should always find ways to pay for any needed legislation so that we do not continue to saddle future generations with a crushing debt.

Before I turn it back to you, Mr. Chairman, I want to briefly mention two bills I have introduced that would provide straightforward solutions for ongoing issues.

First is the Veterans Dialysis Pilot Program Review Act. In 2009, the VA created a dialysis pilot program at four VA medical centers to provide dialysis treatment in local communities using VA clinics versus private contractors. Now, VA intends to roll out the program nationally while at the same time contracting for independent analysis of how well it is working.

In my view, the pilot program should be properly evaluated before starting a national program. So, this bill would direct the VA to halt any new dialysis clinics until the pilot sites have been open for at least 2 years (which was the only general language of the pilot program), an independent analysis of all four pilot sites is conducted, and a report of those analyses is submitted to Congress.

The only intent of this bill is to ensure that before VA creates a national program, we first figure out if that would be in the best interest of our veterans and of our taxpayers.

I have also introduced a bill in response to several recent quality management issues at VA medical facilities that have unfortunately resulted in patient harm and death. These issues range from the misuse of insulin pens, to the outbreak of Legionella, to delays in patient care.

This bill would address overarching themes that were identified as contributing to the poor quality of care of all of these incidents by taking steps requiring VA to have an up-to-date policy about reporting certain infectious diseases and to develop performance measures to assess how well these policies are being followed.

Mr. Chairman, I want to thank you for this legislative hearing, I look forward to hearing from our colleagues, and I look forward to future action on these bills.

Chairman SANDERS. Senator Burr, thank you very much.

We welcome our colleagues who are not on the Committee. Thank you very much for your interest in Veterans Affairs and thank you for being here today.

Let us start with Senator Reed.

**STATEMENT HON. JACK REED,
U.S. SENATOR FROM RHODE ISLAND**

Senator REED. Well, thank you very much, Mr. Chairman, Ranking Member Burr, and distinguished Members of the Committee. Thank you again for the opportunity to speak today regarding legislation that I have introduced to help servicemembers and their families.

S. 1593 is the Servicemember Housing Protection Act. Our country has had a strong tradition of ensuring that the laws that protect our servicemembers keep pace with the challenges they face. Having had the privilege of serving in the Army at, among other places, Fort Bragg, NC, and Fort Benning, GA, I personally know the importance and value of these laws, and I commend you for what you are doing in this Committee.

My proposed legislation would continue this tradition of protecting our servicemen and women, and it seeks to address a continuing challenge, helping them with their housing needs so that they can maintain their focus on the difficult task of protecting our country.

S. 1593, the Service Member Housing Protection Act, takes several critical steps to enhance provisions provided under the Servicemembers Civil Relief Act, SCRA, to our Armed Forces.

First, the bill would make it easier for servicemembers to claim deployment-related financial and credit protections by expanding what could be submitted to constitute, "military orders."

Currently, creditors require a copy of military orders in order to trigger SCRA protections. However, these orders are often not cut until just before deployment or once the servicemember is already deployed which has placed a stressful burden on some families as they try to work with banks to secure SCRA protections.

Broadening the scope of what could be submitted to trigger protections before orders have been received, to include a letter or other form of certification from a servicemember's commanding officer would further ensure that these members have the protections of the SCRA.

Second, this bill would extend foreclosure protections to surviving spouses. Currently, servicemembers have a one-year window of foreclosure protection following service to provide time to reacclimate to civilian life and get their personal affairs back in order.

Our bill extends this 1-year window of foreclosure protection to a surviving spouse who is the successor in interest to the home. After suffering an unspeakable loss of a servicemember, a military spouse should not have the additional burden of dealing with the immediate foreclosure.

Last, the bill would help facilitate the transition from off-base to on-base housing. Due to the shortage of on-base military housing, many servicemembers find off-base housing until on-base housing becomes available.

When servicemembers who are on a waiting list, which can be at least 2 years, are finally given a chance to move into on base housing, they sometimes are not able to terminate their off-base housing lease. Including an order of opportunity to move from off-base to on base housing as additional grounds for termination would allow servicemembers and their families a chance to move into military housing.

Several States—and I must commend them: Florida, Georgia, and Virginia—already have similar laws. We should extend this opportunity to servicemembers serving anywhere in the United States or around the globe.

I am proud to have produced this bill with Senators Begich, Whitehouse, Durbin, and Tester. It is supported by the Military Officers Association of America and also by the Veterans of Foreign Wars.

Mr. Chairman and Members of the Committee, thank you for your important work. Thank you for protecting our veterans. I look forward to working with you on this legislation.

Chairman SANDERS. Senator Reed, thank you very much.
Senator Nelson.

**STATEMENT OF HON. BILL NELSON,
U.S. SENATOR FROM FLORIDA**

Senator NELSON. Thank you, Mr. Chairman. If I may submit my written commentary for the record.

Chairman SANDERS. Without objection.

Senator NELSON. Mr. Chairman, I am just going to tell you what the three pieces of legislation are. The first one is a no-brainer. It is naming the Bay Pines Hospital in the Pinellas County, Florida after the longest-serving Republican member of the House of Representatives who we just lost last week, Bill Young.

His record as Defense Appropriations Chairman, the way he lived his life, where he and his wife literally adopted a Marine who was back from the war and have raised him as their son, and the way that he has reached out to veterans, so much so that the Florida congressional delegation and I conferred last week before his funeral while we were still in recess. The House was in session, and the House took it up and has already passed it, naming the Bay Pines VA hospital after Bill Young.

That is the first piece; and if you could go all on, if you all see fit to move that legislation, it would be a timely thing for the family.

Veterans Conservation Corps. This is for post-9/11 veterans coming home who are unemployed. They would be employed not unlike the old CCC, or Civilian Conservation Corps, for up to 1 year with a possible 1-year extension.

It obviously has a price tag of about a couple of billion dollars. The question is what is the value to society of employing veterans for worthwhile things in our national parks and schools, and I can go into as much detail as you want but that is the idea.

The third piece of legislation is something this Committee has already pushed; electronic health records coming out of the Department of Defense, active duty, as they then go into the VA health care system. Of course, you know the difficulty there so this tries to set a timeline that is achievable; it tells VA and the DOD set your goals, set in the milestones, achieve them, and then have the full implementation of the electronic health records that will allow a seamless transfer which is what we all want.

Those are my three pieces of legislation. Thank you, Mr. Chairman.

[The prepared statement of Senator Nelson follows:]

PREPARED STATEMENT OF HON. BILL NELSON,
U.S. SENATOR FROM FLORIDA

Chairman Sanders, Ranking Member Burr, thank you for the invitation to be here today. I'm honored to speak to the Committee about three pieces of legislation that I've filed to benefit our Nation's veterans.

S. 1576, RE-DESIGNATION OF THE BAY PINES VA FACILITY TO HONOR
REP C.W. BILL YOUNG

On Monday, I filed legislation to rename the Bay Pines VA Healthcare System St. Petersburg, Florida, in honor of Representative Charles William "Bill" Young. I believe this is an appropriate way to recognize his service to the men and women of our military, the State of Florida, and the Nation.

Throughout his long career Representative Young was an unwavering advocate for our Nation's servicemembers and veterans. He served for nine years in the Army National Guard and a further six as a reservist, and in 1970 was elected to the House of Representatives. For over 40 years, and as the longest serving Republican in the House, he represented the needs of the Pinellas County, Florida region, where the Bay Pines VA Healthcare System is located. His willingness to work across the aisle to best represent his constituency was commendable and exemplary of his time in public service.

I strongly support the efforts of the Florida Congressional Delegation and the legislation to rename the Bay Pines VA Healthcare System after Representative Young.

S. 1262, VETERAN'S CONSERVATION CORPS

While the economic downturn has taken a toll on most Americans, it's been especially tough for many of our veterans. According to the Bureau of Labor and Statistics, the unemployment rate of Post-9/11 veterans is 10.1%, much higher than the

national unemployment rate of 7.2%. And with the drawdown in Afghanistan, we can expect newly separated veterans to enter into the workforce at increasing rates. Numbers like these tell me we need to do more to help those who sacrificed in service to our Nation.

This summer, I again filed legislation to authorize a Veterans Conservation Corps. Modeled on the Civilian Conservation Corps of the 1930s, this jobs-program would put veterans back to work restoring and protecting America's public land and waters. Veterans have a history of public service, as well as unique training and skills that could benefit these national priorities, even after their military service has come to an end.

Mr. Chairman, not only will this bill help veterans, but the Veterans Conservation Corps will help address the Federal maintenance backlog. The National Park Service has a deferred maintenance backlog of more than \$11 billion. Federal public lands are not only National treasures, but they are also economic drivers, bringing in tourism and recreational opportunities to local communities. It's been estimated that for each dollar invested in park operations, \$10 in gross sales revenues are generated, and last year, national parks provided \$31 billion of direct economic benefit to local communities around the country.

The Conservation Corps would be overseen by an inter-agency task force—bringing together expertise from the Departments of Agriculture, Commerce, Homeland Security, Interior, the Army Corps of Engineers, and the Corporation for National and Community Service (CNCS). Of note, I am pleased to have the support of the Veterans Administration.

It's up to us to stand by our soldiers, sailors, airmen, marines, and coast guardsmen. Passing legislation to help employ veterans—like the Veterans Conservation Corps—is the way we can thank them for their service and bravery.

S. 1296, ELECTRONIC HEALTH RECORDS

I would also like to discuss my legislation which addresses electronic health records and the ongoing efforts by the Department of Defense and the Department of Veterans Affairs to effectively communicate with one another. The men and women of our Armed Forces sacrifice a great deal for this country and while we recognize the need to provide them with a modern health records system, so far, we have failed to deliver.

The Departments have been pursuing a cohesive system for over fifteen years; putting in hundreds of millions of dollars and countless staff hours, yet the Departments still lack the ability to fully access servicemembers' health records. The lack of access causes delays, increases the backlog of claims at the VA, and has the potential to cause real harm to a servicemember as a result of incomplete or inaccurate health records.

We must not continue kicking the can down the road while servicemembers and veterans are subjected to an untenable system. Goals must be set, milestones achieved, and in the near future, the full implementation of an electronic health records system that allows for the seamless transfer of records between the Department of Defense and Department of Veterans Affairs.

CLOSING

Chairman Sanders, Ranking Member Burr, I appreciate all the work this Committee has done to honor our Nation's veterans and I look forward to working with you on these pieces of legislation.

Chairman SANDERS. Thank you very much, Senator Nelson.
Senator Franken.

STATEMENT OF HON. AL FRANKEN, U.S. SENATOR FROM MINNESOTA

Senator FRANKEN. Thank you, Mr. Chairman and Mr. Ranking Member. I spent the morning with you, too. [Laughter.]

I want to thank you for the opportunity to speak very briefly about my bill, the Rural Veterans Health Care Improvement Act; but before Senator Nelson leaves, I want to associate myself with all three of his.

I think a Conservation Corps for veterans is a great thing, and I think those health records, obviously those electronic health records need to be done as expeditiously as possible.

So, I am here to talk about the Rural Veterans Health Care Improvement Act. I am very pleased to be once again working with my colleague Senator Boozman on this bill. He is not able to be here as he is a conferee on the Farm Bill. As I said the last time I testified here, Senator Boozman's unflappable demeanor and his commitment to veterans are equally renowned.

Our bill, the Rural Veterans Health Care Improvement Act, is on a subject that I know the Chairman cares deeply about, improving the access to quality health care for our Nation's veterans who live in rural areas and I know actually all the Members of this Committee care about that.

My State of Minnesota has a disproportionate number of veterans who live in rural areas and that presents a challenge for getting quality care through the VA. VA has been working on this, but there is room for improvement. That is what our bill would push VA to do.

It would simply tell VA that when it next produces a strategic plan or updates its strategic plan for rural veterans health, there are certain key features that strategic planning has to include, must include.

VA needs to plan strategically about recruiting and retaining practitioners for rural areas, for instance. It has to make full and effective use of mobile outpatient clinics. It has to make sure it is planning for the provision and coordination of care for women veterans in rural areas.

To talk at a little greater length about another aspect of our bill, the VA Inspector General has reported numerous times on challenges faced by veterans in rural areas in getting emergency care. This is understandable. Many rural clinics are not equipped to handle many types of emergencies including mental health emergencies.

We know emergencies will happen and we know they go beyond the capacity of relatively small clinics. We need to be prepared and that means that VA has to make sure that rural health care providers are identifying their clinical capacity and have a contingency plan for how to handle emergencies that exceed that capacity.

I know that VA wants to make this work, wants to do this work and provide the best care possible for rural veterans. I believe the legislation Senator Boozman and I have put forward will help the VA do that. Rural veterans deserve excellent health care no less than their brothers and sisters in urban settings.

So, thank you very much.

Chairman SANDERS. Senator Franken, thank you very much.
Senator Coats.

**STATEMENT OF HON. DANIEL COATS,
U.S. SENATOR FROM INDIANA**

Senator COATS. Mr. Chairman, I am not sure what you and my colleagues did this morning. I am sorry I did not get an invitation.
[Laughter.]

It sounds like it was a pretty good gig.

Senator FRANKEN. It was fun.

[Laughter.]

Senator COATS. Mr. Chairman, I regret that I have to be here to ask you to do something today. Through a mistake made by the VA and their inability to timely address this issue, we have a situation that I think needs to be addressed and I am asking the Committee if you would be willing to support the bill that I introduced, S. 1471, the Alicia Dawn Koehl Respect for National Cemeteries Act.

Let me give you just a bit of background. In May 2012, a veteran, Michael LaShawn Anderson, went on a shooting spree at an Indianapolis apartment complex, injuring three people and taking the life of Alicia Dawn Koehl.

Her parents-in-law are sitting behind me from Fort Wayne, IN. The families have had to go through an excruciatingly lengthy and unproductive process in trying to right a wrong. A mistake was made. Federal law does not allow for burial of a veteran, "if they have committed a Federal or State capital crime but were unavailable for trial due to death." They are prohibited from being given the honor of a burial in a National Cemetery.

To the family's distress, the perpetrator of the crime, Michael Anderson, was buried in a National Cemetery, Fort Custer National Cemetery in Michigan. The family has been asking, since that did violate the law and that is not something I think we want to continue to promote, that the remains be disinterred and buried wherever the family of the person who committed the crime wants to bury them outside of a National Cemetery.

That mistake, and we are going to call it a mistake, by VA needs to be corrected. The family is simply asking for closure and peace of mind that those remains be disinterred. VA's legal department has basically said they do not have the legal authority to do that. And so S. 1471 simply gives them the ability to do that, not only in this case but for potential future cases.

This process has gone on too long. It has been difficult to get to this point. We have spent months and months and months on this. Together, we have worked with VA to fashion this legislation. I simply am asking for the Committee's support for this to hopefully expedite it so that we do not have to wait another year. If it could be done in this Session, I think justice will be served and the family can find some closure from this tragic situation.

So, we appreciate your consideration of this. Anything you can do, colleagues, would be deeply appreciated not just by me but certainly by the family and all of those loved ones of this remarkable woman.

I could tell you some amazing things about her. She lost her life in an unnecessary random shooting that simply took the lives of people for no reason whatsoever. So, whatever help you can give us here we certainly would appreciate.

PREPARED STATEMENT OF HON. DAN COATS ON THE ALICIA DAWN KOEHL RESPECT
FOR NATIONAL CEMETERIES ACT

Chairman Sanders, Ranking Member Burr, and Committee Members: Thank you for the opportunity to testify on behalf of S. 1471, the Alicia Dawn Koehl Respect for National Cemeteries Act. I am pleased to be joined by Alicia Koehl's father-in-law and mother-in-law, Frank and Carol Koehl, who traveled from Fort Wayne, In-

diana, to be here with us today for this important hearing. I would like to ask unanimous consent to include a letter from Alicia's husband, Paul Koehl, in the record.

I truly wish my legislation wasn't necessary. It shouldn't be. I wish the tragic events of May 30, 2012 never took place and there wasn't a need for a bill named after Alicia Koehl. I wish the Department of Veterans Affairs had not made an unacceptable mistake that resulted in even more pain and heartache for this family.

On May 30, 2012, Michael LaShawn Anderson went on a shooting spree at an Indianapolis apartment complex, injuring three people and taking the life of Alicia Dawn Koehl, a devoted wife and loving mother of two children. Anderson killed himself as police were arriving on the scene. Shortly after the Koehl family faced the unimaginable—laying to rest their beloved Alicia—they discovered that the local Department of Veterans Affairs cemetery officials mistakenly granted the shooter a burial with military honors at Fort Custer National Cemetery in Augusta, Michigan on June 6, 2012.

After learning that Anderson was buried alongside our country's heroes in a national cemetery, the Koehl family requested that the VA disinter his remains. Federal law prohibits individuals who "have committed a Federal or state capital crime but were unavailable for trial due to death" from being given the honor of a burial in a national cemetery.

For over a year, my staff and I have been working with the VA and the Koehl family to remove Anderson's remains from the Fort Custer National Cemetery in Michigan. However, earlier this year, the VA informed me personally that it will not disinter the remains of Anderson because the department does not believe it has the legal authority to take this action. In other words, the VA was not permitted under current law to bury Anderson at a national cemetery, but the department doesn't believe they have the legal authority to fix its own mistake and exhume the remains of an ineligible veteran.

My legislation (S. 1471) would right this wrong by granting both the Department of Veterans Affairs and the Department of Defense the authority to disinter veterans buried in national cemeteries who commit a Federal or state capital crime. This bill would give the VA the authority it needs to exhume the remains of Michael LaShawn Anderson.

I urge support for this important legislation. The victims and family members of this tragic shooting have suffered enough and do not deserve to have to wait another year for their request met. No one who commits a state or capital crime should be given the honor of a military burial and be laid to rest next to our Nation's military heroes. By passing this legislation, we can resolve an unacceptable mistake and help provide the Koehl family with a sense of peace and closure. I urge this Committee to pass the Alicia Dawn Koehl Respect for National Cemeteries Act to ensure that our fallen veterans can rest in peace next to loved ones and fellow servicemembers, not criminals.

Thank you.

Chairman SANDERS. Senator Coats, we will certainly take a very hard look at that. We thank you for bringing this to our attention and we very much thank the family for being here as well. We appreciate that.

Senator Heinrich.

STATEMENT OF HON. MARTIN HEINRICH, U.S. SENATOR FROM NEW MEXICO

Senator HEINRICH. Chairman Sanders, Ranking Member Burr, and Members of the Committee, I want to thank you all for the opportunity today to speak about S. 1148, the Faster Filing Act. I was glad to introduce this bipartisan bill with Senator Dean Heller to my left, a Member of this Committee, in order to help reduce the disability claims backlog.

By now, I think every veteran and most Americans have heard of the unacceptable backlog facing our Nation's veterans but not every veteran is aware of a faster filing option to reach a decision quicker and to help avoid the backlog altogether.

As this Committee is aware, the VA's fully developed claims, or FDC, program has allowed servicemembers, veterans, and sur-

vivors to reach faster decisions from the VA on compensation, pension, and survivor benefit claims.

Together in partnership with our Nation's dedicated veterans service organizations, regional offices like the one in Albuquerque, NM, are working hard to promote fully developed claims and break the backlog.

On average, it takes 113 days for veterans to receive a final disability rating if they file a fully developed claim online. Compare that with 373 days if they file a non-fully developed claim on paper.

Specifically, this bill seeks to ensure that veterans are aware of the fastest options that are available to them. It simply does so by requiring the VA to provide notice about the differing processing times of disability claims based on the manner in which the veteran files from an electronic fully developed claim to a non-fully developed claim on paper. This notice would occur prominently on the VA Web site and in each regional office and claims intake facility at the VA.

I am pleased to know that VA has already taken a number of steps since this bill's introduction that are consistent with the intent of the legislation, but more can be done to encourage veterans to submit their claims in the most efficient way possible and this bill is one way to do that.

I also understand there are some suggestions for improving this bill and I certainly look forward to working with the Committee, the VA, and the VSOs to see this bill enacted into law.

Once again, I would like to thank my colleague, Senator Heller, for his help with this legislation.

Chairman SANDERS. Senator Heinrich, thank you very much.

I think we have heard from all of the Senators who are not on the Committee so let us get some opening remarks from Members of the Committee. We will begin with Senator Tester.

**STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA**

Senator TESTER. Mr. Chairman and Ranking Member Burr, I very much appreciate your having this hearing today and thank the VA witnesses, MOAA, VVA, and DAV for participating in this hearing and supporting my legislation. I want to speak briefly about a few bills that I have.

We all know Montana is a rural State. The distance between communities are long. Quality mental health care can be hard to find. The lack of qualified mental health clinicians is a big problem for rural veterans and Montana is no exception, especially for those returning from Iraq and Afghanistan with unseen wounds like PTSD and TBI. Too many living in rural communities go untreated and they pay the price for it.

Improving mental health care in rural America means expanding the use of telemedicine. It means making sure that veterans get the care they need during demobilization. It means improving the VA's use of information technology.

I have introduced the Rural Veterans Mental Health Care Improvement Act this year to tackle these issues. This bill addresses one more critical problem, the lack of qualified mental health professionals working for the VA in rural parts of this country.

I introduced this bill after we held a hearing to highlight the problem and look for solutions. The hearing revealed that not only are there not enough mental health professionals dedicated to working with rural veterans but all too often government agencies are not on the same page when it comes to providing needed care.

The bill also requires the VA to include licensed professional mental health counselors and marriage and family therapists in the Department's flagship recruitment program, the Health Professionals Trainee Program.

These counselors and therapists make up to 40 percent of the overall independent practice out there in the behavioral health workforce nationwide and they often practice in rural areas. But the VA employs fewer than 200 of them in its behavioral health workforce that numbers more than 23,000. That should change.

By bringing more counselors and therapists into the VA's leading health professional training program and providing them with a stipend, more of these professionals will join the VA and make a difference in the lives of America's veterans. With your support, this will become law and more rural veterans, whether in Montana, Alaska, or anywhere in-between, will get the care that they need.

The second bill, S. 1165, would expand performance measures to the entire list of VA and CDC recommended adult vaccinations. This would promote timely and appropriate vaccinations while placing a greater emphasis on preventable care for our veterans.

Each year approximately 70,000 adults die from vaccine preventable diseases. Influenza alone is responsible for 1 million ambulatory care visits, 200,000 hospitalizations, and 30,000 deaths. Vaccinations are one of the safest and most cost-effective ways to prevent disease and death.

To ensure that they are administered in a timely and cost-effective manner, the CDC has recommended an adult immunization schedule that is periodically reviewed and revised. This bill would ensure veterans receive each immunization on the recommended adult immunization schedule established by the CDC.

Finally, the last bill would simply allow the VA to provide dependency and indemnity compensation, DIC, and death pension benefits to the widows of fallen servicemembers and veterans for up to 6 months.

By law, a surviving spouse has to file a claim with the VA before receiving DIC or death pension benefits. Though the majority of DIC and death pension claims will be granted automatically once a claim is filed, the widow loses the veterans benefits immediately upon the veteran's death.

For the most part, these are poverty-level widows. So, in the midst of an incredibly difficult time—we have heard this before—these widows are faced with financial hardship until they file a claim and it is processed. The families of our fallen heroes must be given time to mourn without worrying about how to make ends meet.

Finally, Mr. Chairman, and this is entirely up to you, I heard Senator Nelson's bills. He had three of them. One had to do with the Bill Young naming of a clinic. I think it is entirely possible to get that bill out today, to get it to the floor, get it hot-lined, and move along with that in the short term.

Thank you, Mr. Chairman. I very much appreciate the opportunity to speak. Thanks.

Chairman SANDERS. Thank you, Senator Tester.
Senator Johanns.

**STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEBRASKA**

Senator JOHANNs. Thank you, Mr. Chairman. Thanks for holding this hearing. I do appreciate the opportunity to share a few words on a bill that I have introduced with one of our colleagues from Colorado, Senator Bennet.

I have joined with Senator Bennet in introducing S. 1216. We call it the Improving Job Opportunities for Veterans Act of 2013. This legislation seeks to expand opportunities for veterans using GI Bill benefits to participate in on-the-job training programs and apprenticeship-type training programs.

It would encourage private employers to hire veterans by increasing the VA's contribution to the veteran's salary during the training. It would also help ensure Federal agencies are utilizing the on-the-job training and apprenticeship training benefit to hire veterans.

I believe, and I think Senator Bennet believes, that increasing job opportunities for veterans by ensuring that veterans have the ability to participate in on-the-job training and apprenticeship training programs upon leaving active duty is critically important and this could be a difference maker.

The men and women who have served our great Nation have given a lot. This is one way of helping them out when they return home. As they seek to transition to civilian careers, I believe that this bill will help them make that transition.

I might mention that this legislation overwhelmingly passed the House in May actually by a vote of 416 to 0. So, I would appreciate your consideration of this legislation. I ask my colleagues to join me in supporting it. It is my hope that we can get the bill done.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Johanns.
Senator Hirono.

**STATEMENT OF HON. MAZIE HIRONO,
U.S. SENATOR FROM HAWAII**

Senator HIRONO. Thank you, Mr. Chairman, for holding this hearing today to receive testimony on more than two dozen bills to help our veterans. These bills do a lot of good, from improving dental health services and making mental health services available to veterans and their families, to strengthening job training programs for men and women in uniform.

In particular, I wanted to highlight Chairman Sander's bill, S. 1581, to authorize VA to provide counseling and treatment for military sexual trauma for active-duty servicemembers. This bill will help survivors of sexual assault get the care they need.

I also want to express my support for Senator Durbin's bill, S. 1559. This legislation will ensure that U.S. residents who are Filipino World War II veterans receive the full benefits that they have earned through their service.

We owe all servicemembers and veterans, no matter when and where they served, the care they need and the benefits they have earned, and these measures would help fulfill that commitment.

Finally, I would like to speak for a few moments on S. 1588, a bill that I introduced along with Senators Moran, Isakson, and Begich. This bill provides an emergency safety net to 144,000 veterans waiting for VA care. This bill fixes a Catch-22 in current law that puts veterans who have recently returned from overseas at financial risk if they experience a medical emergency.

Under current law, a veteran enrolled in the VA system who receives emergency care at a non-VA facility can be reimbursed for those costs only if the veteran has also received care at a VA facility in the preceding 24 months.

As I understand it, the intent of this requirement is to encourage veterans to seek preventative care at least every 24 months to decrease the need for more expensive emergency care.

This 24-month requirement creates a problem for some newly returned veterans. They cannot comply with this requirement through no fault of their own. Newly returned veterans cannot comply because they have not received their first VA appointment because of VA waiting times. But, if they need to go to a non-VA hospital for a medical emergency, the VA cannot reimburse them because they have not received their first VA appointments. A Catch-22.

My bill fixes this problem for newly-returned veterans. This bill gives VA the flexibility to reimburse veterans who have not yet received their new patient examination if they have to go to a non-VA hospital for a medical emergency.

For Hawaii, veterans in rural Oahu or on the neighbor islands who live far from VA facilities, emergency care outside the VA may be their only option. Just last week I met a veteran from Waianae, on Oahu, who had a medical emergency while waiting 4 months for his first appointment at VA.

Veterans like him who are denied VA reimbursement would get much-needed relief under this legislation. We owe it to our brave men and women in uniform who put their lives on the line for our country, that VA has the tools it needs to better serve our new veterans accessing the care they have earned.

I look forward to hearing from our witnesses and their thoughts on this and the other bills.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you very much, Senator Hirono.
Senator Isakson.

**STATEMENT OF HON. JOHNNY ISAKSON,
U.S. SENATOR FROM GEORGIA**

Senator ISAKSON. Well, thank you, Mr. Chairman, and I associate myself with all of the remarks by Senator Hirono with regard to her bill on emergency medical services. I think it is a great bill. I am an original cosponsor and completely support it.

I also would urge the Chair to also consider, if it is not inappropriate for me to do so, to consider Senator Tester's request with regard to a UC, or unanimous consent, on the bill naming the veterans facility after Bill Young. Bill was an outstanding member of

the Appropriations Committee for 40 years in the House of Representatives, and passed away last week. I think it is an appropriate and fitting tribute.

Also with regard to Senator Tester's legislation, he has one bill on widows' benefits that says that they get paid immediately upon filing but before they have been approved which is fine with me, but there are cases where sometimes benefits, death benefits, of veterans are contested, where you have more than one spouse in the past.

Having dealt with that in the past, the bill needs to have a reimbursement provision where if it ultimately was denied, the VA is reimbursed for that. That is the only suggestion I would make on that.

Last, Senator Coats from Indiana's presentation with regard to the burial in the cemetery in Michigan, I think that also merits expedited attention.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you very much, Senator Isakson.
Senator Blumenthal.

**STATEMENT OF HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT**

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you for having this hearing.

I want to begin by speaking about a U.S. Marine from Connecticut who unfortunately and tragically took his own life yesterday. I spoke about his tragic loss on the floor of the Senate earlier today.

Justin Eldridge served on active duty in the Marine Corps for 8 years and came back to begin another battle with post traumatic stress and traumatic brain injury. He fought hard. He fought bravely. He fought with the full support of his family, particularly his wife Joanna and his four children; and unfortunately he lost that battle.

I first came to know him when he formed a chapter of the Marine Corps League in southeastern Connecticut and recruited me to join, and I knew him as a dedicated Marine committed to helping his brothers and sisters in the Marine Corps and as a loving husband and father.

We will miss him in Connecticut and I think in the country. But his story shows the importance of the work that we are doing on this Committee today because, as he would be the first to say, there are thousands and thousands like him who are engaged in the same battle, in the same struggle whom we are seeking to help today right here. So, it provides a context and a special meaning for me today.

Turning to the legislation before us, I want to thank all of the witnesses who are going to be with us today for their testimony. It is very, very important that you give us the insight and the benefit of your perspective. I thank you for your service to our Nation as well as your being here today and your contribution to many, many veterans across the country.

One of this Committee's, and indeed the Senate's top priority, should be eliminating the backlog of veterans claims. I appreciate

the VA's commitment to eliminating that backlog and welcome some of the recent positive news that the backlog is declining but unfortunately we are nowhere near where we should be yet and we have to remain vigorous and vigilant in ensuring that the backlog continues to decrease to zero even before the projected date by General Shinseki.

No veteran should have to wait months and months or even years to receive a decision from the VA. Again, taking Connecticut as an example, I recently learned of veterans whose disability claims were approved literally at the beginning of October at a 2-year wait and then had to wait again because of the shutdown to have the full satisfaction and security of knowing that they would receive the disability claims to which they were entitled.

I am proud to cosponsor and support the Servicemembers Electronic Health Records Act. I introduced this bill as an amendment during the Committee's markup in July and I will continue to work to enact it into law.

This bill would require the VA and the Department of Defense medical records to be interoperable in order to create a seamless transition when a servicemember leaves active duty and becomes a veteran and also to allow easy access to VA officials who need a veteran's medical records to decide a veterans claim.

There are two other bills that I have introduced which I will briefly state without going into detail. The first is S. 1281, the Veteran Servicemembers Employment Rights and Housing Act, which I developed with AMVETS and am proud to have the support of the VFW, as well, for this bill. It would include veterans as a protected group in the Equal Employment Opportunity Law and the Fair Housing Act.

Another bill that I introduced actually yesterday, the Toxic Exposure Research and Military Family Support Act, I was pleased to do with the support and tremendous contributions of the Vietnam Veterans of America. This is a comprehensive effort to provide for veterans who were exposed to danger us toxic substances during their military service and for their loved ones.

We have seen alarming trends in children of veterans exposed to Agent Orange. Many have childhood cancer, heart attacks or other serious conditions. This bill is really an attempt to have the VA look at each incident of toxic exposure in the military on its own merits and its own facts to determine the effect on veterans and their dependents.

I am working with a variety of VSOs on this legislation and other legislation which I support, including S. 1211, which would ensure that the phrase "GI Bill" cannot be used under false pretenses; and the World War II Merchant Mariner Service Act which affects many of our constituents who served our country honorably during World War II in the Merchant Marines and deserve treatment under this bill.

I also would like to be added as a cosponsor and supporter of S. 1262, Senator Nelson's Conservation Corps Bill; S. 1155, Senator Tester's Rural Mental Health Act.

I thank you, Mr. Chairman.

Chairman SANDERS. Thank you very much, Senator Blumenthal. Senator Heller.

**STATEMENT OF HON. DEAN HELLER,
U.S. SENATOR FROM NEVADA**

Senator HELLER. Thank you, Mr. Chairman. Thank you and the Ranking Member for holding this hearing. Before I begin, I want to thank you for your opening comments about bipartisanship which, in these halls it is hard to find sometimes and I think the work that you and Senator Burr do together moves this Committee forward.

For someone watching what is going on both sides, both chambers on the floor, it is a breath of fresh air. So, thank you very much for your leadership on that.

I want to also thank Senator Isakson and support him in his request to move Senator Nelson's and Senator Coats' request. I think that would be appropriate and I cannot imagine there would be any opposition.

I would like to focus my remarks on the VA's disability claims backlog. When I joined this Committee, I made it one of my top priorities to bring the backlog of claims down and joined Senator Casey to establish the VA Backlog Working Group.

All parties have acknowledged the gravity of this problem. I continue to work with veterans service organizations and other members of Congress and the VA to address this particular problem.

Hundreds of Nevada veterans and their family members in Las Vegas and Reno have come to my office to express their frustration with wait times and to seek assistance navigating through this very difficult process.

During roundtables in Nevada's communities, veteran advocates told me that the VA backlog has directly impacted the welfare of these individuals. While the VA has made progress toward reducing the backlog, the Reno VA regional office still has more than 4,000 veterans that have waited over 125 days for decisions on their claims.

This is a problem that I know we all want to fix. Democrats, Republicans, the President, Secretary Shinseki are all concerned about this issue and want to see it solved.

It is clear that we need to do more to fix this problem and to fix it permanently. That is why I have joined with Senator Heinrich to introduce bipartisan legislation that gives veterans information about the timeliness of the fully-developed claims program.

The Veterans Benefits Claims Faster Filing Act ensures that veterans are fully informed of the filing options available to them. The VA will be required to provide information online and in each VA regional office about which options will result in a quicker decision.

When veterans submit a fully-developed claim with all evidence ready for the claims process, the claim is completed in less than 125 days on average, meeting the VA's deadline before a claim becomes backlogged. However, claims that are not fully developed often take more than a year to process. Providing accurate information to veterans before they submit a claim will save time for both the veteran and the VA themselves.

The VA would also be required to inform veterans that filing a fully-developed claim makes them eligible to receive an additional year of benefits as authorized under current law. It is important that veterans are encouraged to file a fully-developed claim so that

fewer individuals experience the frustration of waiting for benefits they have earned in service to our country.

While there is no single bill that will magically reduce the backlog, I believe that targeted legislation like Senate Bill 1148 takes us another step forward to helping our Nation's veterans and the VA reach this goal. I do appreciate Senator Heinrich's remarks on our legislation and look forward to working with him to move this bill forward.

Mr. Chairman, I would also like to express my support for Senator Tester's bill, the Military Family Relief Act, which I am proud to be a cosponsor of. This legislation authorizes the Veterans Benefits Administration to automatically and immediately provide death and indemnity compensation and death pension benefits to widows and widowers of fallen servicemembers and veterans.

Currently, widows and widowers are not eligible to receive these needed benefits until they file a claim and it is approved. The process can take months. At a time when a family is grieving over the loss of a loved one, these individuals should not also feel burdened by the financial strain of having to wait several months for these benefits. I am glad to support Senator Tester in this effort and hope to see it move forward.

As this Committee further discusses proposals to help American veterans receive the benefits they have earned, it is my hope that we will remember our commitment to caring for these brave heroes who have sacrificed greatly to serve this country.

Thank you very much, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Heller. I think we have now heard from all of the sitting Members of the Committee and we are ready for our first panel.

We thank our panelists very much for being with us this afternoon. From the Department of Veterans Affairs, we have Dr. Robert L. Jesse, the principal Deputy Undersecretary for Health. Dr. Jesse, thanks for being here.

Also joining us today from VA is David McLenachen, the Director of the Pension and Fiduciary Services for the Veterans Benefits Administration, and we thank you very much for being here.

Rounding out this panel are Assistant General Counsel Richard Hipolit and Deputy Assistant General Counsel Jane Clare Joyner.

The Department's full statement will be entered into the record. Dr. Jesse, please begin.

STATEMENT OF ROBERT L. JESSE, M.D., Ph.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Thank you, sir. Good afternoon, Chairman Sanders, Ranking Member Burr, and Members of the Committee and thank you for the opportunity to be here today.

Sir, I very much appreciate your positive comments about both the quality and value of VA health care and your admonishment to the timeliness of our formal views. Noted, and we will make sure that word is carried back.

We appreciate very much the efforts of the Committee to improve veterans' health care. As you have already stated, with the number

of bills on the agenda, we are really only today able to have some very broad comments before fielding your questions.

There are a number of more significant bills I think we received really too late to include in the testimony but I want to assure you that we will be following up with a substantive discussion.

As you know, one of Secretary Shinseki's top priorities is, in fact, access for veterans. That includes access into the system in a timely fashion which is much of the issue with getting into the benefits system but also access to timely and quality health care within our side of the system.

We have been very aggressive about getting access to care close to where veterans live through aggressive outreach as well as through the use of telehealth, connected health strategies.

There are significant bills on the agenda that aim at expanding access to health care services as well as dental care. The agenda also includes bills on the important topics of our care for victims of military sexual assault and domestic violence as well as expanding mental health support and the promising alternatives to institutional care across the health care spectrum.

We do appreciate the dialog that we have had with your staff, especially regarding the draft bill on eligibility and access. There are some operational complexities that we note in our written testimony. We also believe that there are some provisions in there that are intertwined with the Affordable Care Act and will take a little more time to work out through coordinating with partners in departments of Health and Human Services and Treasury.

Again, I want to be very plain that the VA, the Secretary, no one wants more than to ensure access to and quality of care at the VA, but we do need to be mindful of both current capacity within the system and the effect that any eligibility, significant eligibility changes might have on the services we have already committed to veterans under our care.

A number of these bills, many of these bills we, in fact, wholeheartedly agree with in terms of concept and direction and intent; some of which, however, we think we are already doing under current authorities and it may be well served by improved communication.

This includes S. 1165 regarding immunizations; S. 1411, defining the components of the strategic claim for rural health. We have a comprehensive approach of addressing both of these topics already.

Regarding S. 1547, VA plans to fully brief the Committee on the results of the dialysis pilot program before we expand into any additional freestanding dialysis clinics, and I do wish to assure the Committee that we are actively evaluating the data from the pilots as they are being generated, and we intend to render an expansion decision only after that has been fully understood.

Our concern is that this bill would, as it states, prevent us from activating any further freestanding dialysis centers until after July 2015 because the last center did not get operational—that is the one in Cleveland, OH—until after in July 2013.

That is the main reason we are not supporting the bill, but we would like to continue to work with the Committee to ensure that we are taking all steps possible to maintain and ensure future access to effective dialysis care for veterans.

That concludes my oral statement. I will turn to my colleague Dave McLenachen, who will comment briefly on the other bills on the agenda.

STATEMENT OF DAVID R. McLENACHEN, DIRECTOR, PENSION AND FIDUCIARY SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY RICHARD HIPOLIT, ASSISTANT GENERAL COUNSEL; AND JANE CLARE JOYNER, DEPUTY ASSISTANT GENERAL COUNSEL

Mr. McLENACHEN. Thank you, Dr. Jesse.

Good afternoon, Mr. Chairman, Members of the Committee. I am also pleased to have the opportunity to comment on the bills before the Committee today and like Dr. Jesse, in the interest of time, I will keep my comments brief.

As he also noted, bills not covered in our written testimony will be addressed in our follow-up views. That applies to the Veterans Benefits Administration bills that did not make our testimony. We will provide those to the Committee as soon as possible.

Mr. Chairman, we appreciate the Committee's partnership as we work to meet the Secretary's goals to reduce our disability claims backlog while maintaining a high standard of quality. We also appreciate the introduction of two bills, S. 1148 and S. 1295 regarding the information that VA provides to claimants and the public.

The availability of VSO assistance and performance metrics. We agree with the concepts presented in these bills but feel that VA has been successful in furthering the aims of the bills under current law.

While we support veterans having access to good information and establishing a method for stakeholders and the VA to measure our progress, these bills may have unintended consequences. We welcome the opportunity to work with the Committee to address our concerns.

We appreciate the introduction of draft legislation that would modernize the actuarial basis for our service-disabled veterans insurance program. This change is overdue and would provide greater financial security for our disabled veterans and their families to lower insurance premiums, provided that there are corresponding offsets to fund the proposed amendment.

We also support and appreciate bills on the agenda that would enhance our on-the-job training authorities and help protect veterans from those who misrepresent that they are acting as the VA's endorsement when they promote services associated with post-9/11 GI Bill.

We were also pleased to see S. 1262 on the agenda which is a measure to provide job opportunities for veterans in conservation, first responder, and a law enforcement fields which is similar to the Administration's Veterans' Job Corps proposal.

VA also supports S. 1471 which would give the Secretary authority to address those rare cases that you heard about today in which a National Cemetery buries a veteran without notice that the veteran may have committed a capital offense.

Finally, VA appreciates this Committee's continued efforts on our outreach. We agree with the importance of partnerships with other

Federal agencies, State and local officials, and nonprofits to inform veterans and their families about the benefits that they have earned. Our testimony includes examples of how we are meeting the goals expressed in S. 1558.

Mr. Chairman, this concludes my oral statement. My colleagues and I are happy to answer any questions that in the Committee may have.

[The joint prepared statement of Dr. Jesse and Mr. McLenachen follows:]

PREPARED STATEMENT OF ROBERT I. JESSE, M.D., PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH AND DAVID R. MCLENACHEN, DIRECTOR, PENSION FIDUCIARY SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good Morning Chairman Sanders, Ranking Member Burr, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect Department of Veterans Affairs (VA) healthcare and benefits programs and services. Joining us today are Richard Hipolit, Assistant General Counsel, and Jane Clare Joyner, Deputy Assistant General Counsel.

VA is still in the process of formulating views on the following bills for which VA received notice or drafts on September 30, 2013: Sections 3–5 of S. 1155, S. 1296, S. 1540, S. 1556, and S. 1559. We will forward the views and estimates to the Committee as soon as they are available. Other bills were provided to VA at various points during the month of October. VA also will provide views and costs to the Committee on those bills at a later time: S. 1573, supplemental analysis to what is presented in this testimony regarding the draft bill entitled the “Veterans Health Care Eligibility and Expansion Act,” views and costs on the draft bills entitled “Mental Health Support for Veterans Families and Caregivers,” the “Survivors of Military Sexual Assault and Domestic Abuse Act,” the “Medical Foster Home Act,” and a draft bill regarding eligibility for emergency medical treatment.

Additional bills provided to VA during October for which views will be provided for the record are: draft bills entitled the “Enhanced Dental Care for Veterans Act,” the “Improved Compensation for Hearing Act,” the “SCRA Enhancement and Improvement Act,” the “Ensuring Safe Shelter for Homeless Veterans Act; the “Servicemember Housing Protection Act;,” the “Support for Joint Federal Facilities Act,” a bill to re-designate the name of a VA Medical Center, a bill regarding replacement automobiles for certain disabled veterans, a bill concerning the health conditions of descendants of Veterans exposed to toxic substances during service in the Armed Forces, and finally a bill concerning infectious disease reporting and the organizational structure of VHA.

S. 1148—VETERANS BENEFITS CLAIMS FASTER FILING ACT

Section 2(a) of S. 1148, the “Veterans Benefits Claims Faster Filing Act,” would require VA to post in a conspicuous place in each regional office and claims intake facility and on VA’s internet Web site information concerning the average processing times for claims based on various formats in which a claim can be submitted, and information concerning the percentage of claims for which benefits are awarded, categorized by whether the claimant was represented by a Veterans Service Organization (VSO), a representative other than a VSO, or not represented via a durable power of attorney. The bill would require such information to be updated at least quarterly. Section 2(b) of the bill would require VA to provide each claimant with the same information. Section 2(b) would further require VA to notify each claimant that he or she may become eligible for up to one extra year of benefit payments by submitting a fully developed claim (FDC). The notice required by section 2(b) would have to be provided before the recipient submits a claim.

VA understands and appreciates the importance of transparency and the need to keep Veterans, Congress, and other stakeholders informed. There are currently many ways for Veterans, VSOs, and others to get information and data about claims. For example, information is included in our annual budget request to Congress, the Annual Benefits Report, the annual Performance and Accountability Report, monthly ASPIRE updates, monthly Congressional Tracking Reports, the Monday Morning Workload Report, various Veterans Benefits Administration (VBA) Web sites (including www.eBenefits.va.gov), responses to calls at our National Call Centers, and other responses to specific requests from Members of Congress, stakeholders, and the media.

VA does not support this bill, for several reasons. The bill would create a significant administrative burden that would effectively delay the processing of disability compensation claims. The requirement that VA provide certain information to each claimant potentially would require VA to revise a number of forms and would implicate the requirements of the Paperwork Reduction Act, requiring two periods of public notice prior to changing the form. VA currently provides notice on FDC forms stating that the FDC program is the fastest way to receive a decision on a claim. Soon, VA will be revising the notice to inform claimants of the potential entitlement to an extra year of benefit payments for original FDC claims.

VA has concerns about the complexity of data that would be required based on the bill. Some of the metrics outlined in the bill are not currently available in VA systems. For example, VA generally does not routinely track grant rates for particular types of claims or whether claims are submitted in standard or non-standard paper form. Similarly, the term “for which benefits are awarded,” as used in section 2(c) of this bill, is ambiguous. Awards of service connection for a disability evaluated at zero percent do not result in payment. Disability compensation claims can involve a single disability contention or multiple contentions, and several claims from the same individual may simultaneously await resolution. It is unclear whether VA would be required to report awards per claimant, per claim, or per individual contentions within each claim.

The complex data that would be provided under the bill could easily mislead or confuse claimants rather than help them understand what they should do to support their claims. Providing this type of information could be seen as directing claimants to file, or not file, certain types of claims or to elect a particular type of representative. However, the data provided may not be the best indicator of the most appropriate course of action for the particular claimant. Also, reporting the percentages of claims with a power of attorney naming a VSO may be misleading, as Veterans with authorized VSOs often file claims without the direct involvement of their designated VSOs. Furthermore, most powers of attorney used to authorize claim representatives are not “durable.”

VA also notes that H.R. 1148 does not specify which VA benefit(s) would be impacted by this bill. Although VA believes the bill is likely intended to apply to claims for service-connected disability compensation, the bill does not explicitly state this and would therefore apply to all benefits. Further, although the bill would require VA to notify each claimant of the availability of an extra year of benefit payments if a person files a FDC, section 506 of Public Law 112–154, which authorizes a one-year retroactive payment for persons who file FDCs, applies only to original (i.e., initial) claims by Veterans for disability compensation. Providing notice of the retroactivity provision to persons claiming other benefits, or to Veterans attempting to reopen disability compensation claims or to claim increased compensation, may be confusing and misleading. In addition, the FDC retroactivity provision has a sunset date, while the bill would require in perpetuity notice of the availability of the benefits.

VA estimates that there would be no benefit costs associated with enactment of S. 1148. VA estimates the general operating expenses (GOE) for section 2 of S. 1148 would be \$5.5 million in the first year, \$27.7 million over five years, and \$58.8 million over ten years. VA estimates the information technology (IT) costs for section 2 of S. 1148 would be \$122,000 in the first year, \$655,000 over five years, and \$1.4 million over ten years.

S. 1155—RURAL VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT

Section 2 of S. 1155 would amend section 117(c) of title 38, United States Code, to add accounts providing funds for information technology, including subaccounts of the medical services, medical support and compliance, and medical facilities accounts, to the list of accounts in section 117 that receive advance appropriations.

We appreciate how Congressional support for VA advance appropriations for our medical care accounts has enabled a multi-year approach to medical budget planning and ensured continued medical services for Veterans. The advance medical care appropriation was designed to ensure continuity of critical medical operations in the face of fiscal uncertainty.

A proposal to expand VA advance appropriations to other accounts needs to take into consideration the advantages and disadvantages of such an approach not only for VA, but potentially other programs and agencies. We cannot therefore offer a position on section 2 of S. 1155 at this time. We very much appreciate the concern for Veterans services reflected in the proposal, and look forward to working with the Committee on how to best maintain the provision of VA benefits and services in light of fiscal uncertainties.

We are finalizing our views and costs on sections 3–5 of S. 1155. We will forward the views as soon as they are available.

S. 1165—ACCESS TO APPROPRIATE IMMUNIZATIONS FOR VETERANS ACT OF 2013

S. 1165 would amend section 1701 of title 38, U.S.C., to include certain adult immunizations as part of the preventive services detailed in subsection 9 of the statute. The bill would also amend section 1706 of title 38, U.S.C., to require VA to develop quality measures and metrics to ensure that Veterans receiving medical services also receive the immunizations.

VA strongly supports preventive care measures, including making a wide range of immunizations available at VA medical facilities. However, because we believe VA is already satisfying the purpose of this bill, we do not support this legislation.

Under current policy, VA already provides preventive immunizations at no cost to the Veteran. In addition, VHA is represented as an ex-officio member of the Advisory Committee on Immunization Practices (ACIP) and VA develops clinical preventive services guidance statements on immunizations in accordance with ACIP recommendations (VHA Handbook 1120.05). All ACIP-recommended vaccines are available to Veterans at VA medical facilities. These vaccines currently include: hepatitis A, hepatitis B, human papillomavirus, influenza, measles/mumps/rubella, meningococcal, pneumococcal, tetanus/diphtheria/pertussis, tetanus/diphtheria, varicella, and zoster. As the ACIP recommendations change, VHA policy reflects those changes.

The delivery of preventive care including vaccinations has been well established in the VHA Performance Measurement system for more than 10 years with targets that are appropriate for the type of preventive service or vaccine. VA updates the performance measures to reflect changes in medical practice over time. Adding the additional legislative process of regulations to the development of targets would be burdensome and lengthy.

Moreover, the legislative process does not allow for nimble changes as new research or medical findings surrounding a vaccine come to light. Because the clinical indications and population size for vaccines vary by vaccine, blanket performance monitoring of all vaccines can be cost prohibitive and may not have a substantial positive clinical impact.

S. 1211—REGARDING THE USE OF THE PHRASES “GI BILL” AND “POST-9/11 GI BILL”

S. 1211 would amend chapter 36 of title 38, United States Code, to add a new section 3697B, which would prohibit, except with the written permission of the Secretary, the use of the words and phrases “GI Bill” or “Post-9/11 GI Bill” in connection with any promotion, goods, services, or commercial activity in a manner that reasonably and falsely suggests that such use is approved, endorsed, or authorized by VA or any component thereof. A determination that the use of one or more words or phrases covered by section 3697B does not violate that section could not be based solely on the ground that such use includes a disclaimer of affiliation with VA or any VA component. S. 1211 would authorize the Attorney General of the United States to initiate a civil proceeding in a district court to enjoin an existing or potential violation of section 3697B. Further, S. 1211 would specify that the district court could, at any time before final determination, enter such restraining orders or prohibitions, or take such other action as is warranted, to prevent injury to the United States or to any person or class of persons for whose protection the action is brought.

VA supports this bill. VA has already taken action to prevent the misuse and misrepresentation of the phrase “GI Bill.” The phrase “GI Bill” is a trademark owned by VA and registered with the U.S. Patent and Trademark Office as of October 16, 2012. If this bill were enacted, it would assist in further diminishing aggressive advertising toward Veterans, as addressed in Executive Order 13607: Establishing Principles of Excellence for Educational Institutions Serving Servicemembers, Veterans, Spouses and Other Family Members.

VA estimates there would be no costs to VA associated with implementing this bill because, according to the bill text, the Attorney General’s office would be responsible for enforcing the prohibition. If VA was notified of, or became aware of, prohibited use of the phrases “GI Bill” or “Post-9/11 GI Bill,” VA would refer the incident to the Department of Justice (DOJ).

S. 1216—IMPROVING JOB OPPORTUNITIES FOR VETERANS ACT OF 2013

Section 2 of S. 1216, the “Improving Job Opportunities for Veterans Act of 2013,” would reduce, during the 4-year period beginning on the date that is one year after the date of enactment, the amount of wages paid the eligible Veteran or person in

an OJT program not later than the last full month of that training period from 85 percent to 75 percent of the wages paid for the job for which such individual is being trained

Section 3 of the draft bill would require VA, beginning 1 year after the date of enactment, to enter into agreements with other Federal departments and agencies to operate their own OJT programs under section 3677 of title 38, United States Code, to train eligible Veterans or persons in skills necessary to obtain employment by those entities. Finally, section 4 of the draft bill would extend from November 30, 2016, until December 31, 2016, the requirement in 38 U.S.C. § 5503(d) to reduce pension payments for certain beneficiaries who receive services from a nursing facility under a Medicaid plan.

VA does not object to the provision in section 2 that would temporarily reduce the wage requirement from 85 percent to 75 percent, subject to Congress identifying appropriate offsets for the increased benefit costs that would result from the increased participation in the OJT program. VA anticipates that this amendment may increase employer and Veteran participation in OJT programs, increasing the number of job-training programs for Veterans in the future. However, VA cannot determine how much OJT participation would increase until more data become available after the implementation of this program. VA supports the intent underlying section 3; however, we do not believe legislation is necessary because VA currently has the authority to approve Federal OJT and apprenticeship programs under section 3672(b) of title 38, United States Code. Furthermore, the bill is unclear as to: (1) the purpose of such agreements beyond VA approval (For instance, it could be to document exchange of funds, specify program content, or require or commit such departments/agencies to carry out such training); and (2) what entity would provide the training (VA or the other Federal department/agency).

VA will provide views and a cost estimate for section 4 of the bill for the record at a later date.

S. 1262—VETERANS CONSERVATION CORPS ACT OF 2013

Section 2(a) of S. 1262 would require the Secretary of Veterans Affairs, in cooperation with the Attorney General, the Secretary of Agriculture, the Secretary of Commerce, the Secretary of Homeland Security, the Secretary of the Interior, and the Chief of Engineers, to establish a Veterans conservation corps to assist Veterans in the transition from service in the Armed Forces to civilian life and to employ Veterans in conservation, resource management, and historic preservation projects on public lands and maintenance and improvement projects for cemeteries under the jurisdiction of the National Cemetery Administration; and as firefighters, law enforcement officers, and disaster relief personnel. This bill would establish a priority for Conservation Corps hiring for Veterans who served after September 11, 2001.

Section 2(b) of the bill would require as part of the Veterans conservation corps that the Secretaries of Veterans Affairs, Agriculture, Commerce, and the Interior and the Chief of Engineers employ Veterans; or award grants to, or enter into contracts with State governments, local governments, or nongovernmental entities, to employ Veterans to carry out the projects described in section 2(a) of the bill.

Section 2(c)(1) of the bill would require as part of the Veterans conservation corps that the Secretary of Homeland Security award grants under section 34 of the Federal Fire Prevention and Control Act of 1974 to hire Veterans as firefighters. Section 2(c)(2) of the bill would require the Attorney General to award grants under part Q of title I of the Omnibus Crime Control and Safe Streets Act of 1968 to hire Veterans as law enforcement officers. Section 2(c)(3) would require the Secretary of Homeland Security to provide funds to increase participation by Veterans in the Federal Emergency Management Corps program.

Section 2(d) of the bill would authorize the Secretary of Veterans Affairs to provide assistance to the officials listed in section 2(a) of the bill to carry out the Veterans conservation corps. Such assistance could take the form of transfers from amounts appropriated or otherwise made available to the Secretary of Veterans Affairs to carry out the Veterans conservation corps. Section 2(d)(3) of the bill would require the Secretary of Veterans Affairs to establish a steering committee consisting of the Secretaries of Veterans Affairs, Agriculture, Commerce, and the Interior and the Chief of Engineers to establish selection criteria and provide advice in connection with award of assistance as authorized under section 2(d) the bill.

Section 2(e) of the bill would require the Secretary of Veterans Affairs to establish a reporting framework to ensure proper oversight and accountability of the Veterans conservation corps. Section 2(f) of the bill would require the Secretary of Veterans Affairs to ensure that Veterans employed under the Veterans conservation corps are aware of benefits and assistance available to them under the laws administered by

VA. Finally, Section 2(g) would authorize appropriations to the Secretary of Veterans Affairs to carry out the bill in the amount of \$600,000,000 for the period of FY 2014 through FY 2018.

S. 1262 includes similar concepts to the Administration's Veterans Job Corps proposal presented in its Fiscal Year 2014 budget. VA would welcome the opportunity to work with the Committee on this bill.

S. 1281—VETERANS AND SERVICEMEMBERS EMPLOYMENT RIGHTS AND HOUSING ACT OF 2013

S. 1281, the "Veterans and Servicemembers Employment Rights and Housing Act of 2013," would prohibit discrimination in employment and housing on the basis of military service. Section 2 of S. 1281, which would prohibit employment-related discrimination on the basis of military service, would affect programs or laws administered by the Equal Employment Opportunity Commission (EEOC) and Office of Personnel Management (OPM). In addition, section 2(g), which addresses employment practices related to national security, would affect matters under the jurisdiction of Department of Homeland Security (DHS). Section 3, which would prohibit residential housing-related discrimination on the basis of military service, would affect programs or laws administered by the Department of Housing and Urban Development (HUD). In addition, both sections 2 and 3 of the bill relate to matters of Department of Justice (DOJ) enforcement. Further, because S. 1281 addresses current as well as former members of the uniformed services, the bill would involve matters related to Department of Defense (DOD). Accordingly, we defer to those departments' views on this bill. We understand that DOJ appreciates the goals of the bill, but may suggest alternative approaches more consistent with current enforcement schemes.

S. 1295—REGARDING NOTICE TO VETERANS FILING ELECTRONIC CLAIMS FOR BENEFITS OF THE AVAILABILITY OF SERVICES FROM VETERAN SERVICES ORGANIZATIONS

S. 1295 would add to title 38, United States Code, a new section 5103B, which would require, "[t]o the degree practicable," VA to notify claimants, when they electronically file applications for VA benefits, that relevant services may be available from VSOs. S. 1295 would also require VA to provide claimants a list of VSOs and applicable contact information.

VA appreciates the intent of S. 1295, but does not support the bill because VA has been able to carry out its purpose under current law. VA already notifies claimants who file claims electronically that VSO representation is available. In addition, VA already provides claimants easy access to information about claim representation from VA-accredited VSO representatives, claims agents, and attorneys. For example, the electronic benefits Web site (<http://www.ebenefits.va.gov/>) provides a link to a directory of all VA-recognized VSOs with their contact information. This directory is searchable and allows a claimant to search for VA-accredited VSO representatives, claims agents, and attorneys by location. Although VA views the bill as unnecessary, VA supports the intent of the bill and will continue to ensure that notice of available representation is clearly indicated on its electronic application portal, eBenefits.

VA estimates that there would be no benefit costs or GOE costs associated with enactment of this bill.

S. 1361—WORLD WAR II MERCHANT MARINER SERVICE ACT

S. 1361, the "World War II Merchant Mariner Service Act," would direct the Secretary of DHS to accept certain types of evidence for verifying that an individual performed honorable service as a coastwise merchant seaman during the period beginning on December 7, 1941, and ending on December 31, 1946, for purposes of eligibility for certain Veterans' benefits. Although service as a merchant seaman does not generally constitute active duty service conferring eligibility for Veterans' benefits, the GI Bill Improvement Act of 1977 authorized DOD to designate the service of certain groups as active duty service sufficient to confer eligibility for Veterans' benefits. Pursuant to that authority, DOD has determined that the service of the "American Merchant Marine in Oceangoing Service during the Period of Armed Conflict, December 7, 1941, to August 15, 1945," shall constitute active duty for purposes of eligibility for Veterans' benefits.

DHS is responsible for verifying that an individual served in the American Merchant Marine in oceangoing service during the specified period. A finding in section 2 of S. 1361 identifies the types of documentation DHS currently accepts to establish such qualifying merchant-seaman service. Section 3 of S. 1361 would direct DHS to accept certain alternative types of evidence as sufficient to establish qualifying merchant-seaman service for purposes of certain Veterans' benefits and other

purposes. In the absence of a Coast Guard shipping or discharge form, ship logbook, merchant mariner's document or Z-card, or other official employment record, the alternative sources of evidence would include Social Security Administration records together with validated testimony and other official documentation. Under section 3(c) of the bill, a finding of qualifying active duty service based on such alternative forms of evidence would establish eligibility for burial benefits under chapters 23 and 24 of title 38, United States Code, but would not establish eligibility for other Veterans' benefits. Section 3(c) would further provide that a person found to have qualifying service pursuant to this bill would be eligible for applicable medals, ribbons, and military decorations and would be "honored as a veteran," but would not be entitled to Veterans' benefits other than those specified in the bill.

VA supports measures to ensure that individuals who have qualifying service can establish eligibility for the benefits they have earned. However, because DHS, rather than VA, is responsible for the service verifications to which this bill pertains, VA defers to the views of DHS regarding section 3 of this bill.

VA's National Cemetery Administration (NCA) has not encountered significant difficulties in obtaining verification of qualifying oceangoing service in the merchant marine. NCA reviewed the number of cases in its Burial Operations Support System from September 25, 2012, through June 10, 2013, that listed Merchant Marine as the Branch of Service. NCA approved 168 requests for burial, while only three requests were denied because qualifying oceangoing service during World War II was not established.

VA cannot determine whether this bill would lead to any increase in the provision of burial benefits to merchant mariners and their survivors. Therefore, VA cannot provide a cost estimate.

S. 1399—AMENDING THE SERVICEMEMBERS CIVIL RELIEF ACT

S. 1399 would extend the interest rate limitation on debts incurred before military service to debts incurred during military service to consolidate or refinance student loans incurred before military service. This bill would affect issues relating to current members of the uniformed services and consequently is of primary concern to DOD. The bill further relates to matters of the Department of Education, the Consumer Financial Protection Bureau and DOJ enforcement. Accordingly, we defer to those agencies' views on this bill.

S. 1411—RURAL VETERANS HEALTH CARE IMPROVEMENT ACT OF 2013

S. 1411, Rural Veterans Health Care Improvement Act of 2013 (the "Act"), would direct the Department to apply specified consultation, information, and transmittal requirements when issuing VHA's planned update of the 2010–2014 Strategic Plan of the VHA Office of Rural Health (ORH). Specifically, the bill would require the ORH update or successor plan to be prepared in consultation with the Director of VHA's Office of Health Care Retention and Recruitment, the Director of Quality and Performance, and the Director of Care Coordination Services. It would also have to include the following information (relevant to the reporting period):

- Goals and objectives for the recruitment and retention of health care personnel in rural areas;
- Goals and objectives for ensuring timeliness and improving quality in the delivery of health care services in rural areas through contract and fee-basis providers;
- Goals and objectives for the implementation, expansion, and enhanced use of telemedicine services in rural areas, including through coordination with other appropriate offices of the Department;
- Goals and objectives for ensuring the full and effective use of mobile outpatient clinics for the provision of health care services in rural areas, including goals and objectives for the use of such clinics on a fully mobile basis and for encouraging health care providers who provide services through such clinics to do so in rural areas;
- Procedures for soliciting from each VA facility that serves a rural area the following information: the clinical capacity of facility; the procedures of such facility in the event of a medical, surgical, or mental health emergency outside the scope of the clinical capacity of such facility; the procedures and mechanisms of such facility for the provision and coordination of health care for women veterans, including procedures and mechanisms for coordination with local hospitals and health care facilities, the oversight of primary care and fee-basis care, and the management of specialty care;
- Goals and objectives for the modification of the funding allocation mechanisms of the ORH to ensure that the Office distributes funds to components of the Department to best achieve the goals and objectives of the Office and in a timely manner;

- Goals and objectives for the coordination of, and sharing of resources with respect to, the provision of health care services to veterans in rural areas between the VA, DOD, the Indian Health Service of the Department of Health and Human Services (HHS), and other Federal agencies, as appropriate and prudent;
- Specific milestones for the achievement of the goals and objectives developed for the update; and
- Procedures for ensuring the effective implementation of the update.

Finally, S. 1411 would require the Secretary to transmit the first update (or successor plan) to Congress not later than 90 days after its issuance, along with comments and recommendations deemed appropriate.

VA believes the bill is duplicative of both past and continuing Departmental efforts and thus does not support S. 1411. Specifically, ORH produced a 5-year strategic plan for FY 2010–2014 to ensure that ORH programs and initiatives meet the health care needs of rural Veterans. That plan was refreshed in FY 2011 to better align ORH resources with identified health care needs, especially in light of new technologies and delivery systems for rural Veterans.

Further, ORH is currently developing a new strategic plan for FY 2015–2019 to better align our goals with those outlined in the FY 2013–2018 VHA strategic plan to better serve the future health care needs of rural Veterans given the changing landscape of health care delivery and access and the stronger emphasis on prevention and community wellness. Goals of the FY 2015–2019 ORH strategic plan include strategic dissemination and integration within and outside VA of best practices in rural health care delivery to increase access and quality; strengthening of the rural health infrastructure through partnerships and collaborations with other Federal and community entities; enhancing rural provider capacity through increased student clinical training opportunities in rural areas and increased rural provider training opportunities; and enhancing rural telehealth capabilities. ORH will also continue to evaluate its on-going programs, including the pilot and demonstration projects that ORH currently funds across the VA health care system, in order to assess their effectiveness in delivering quality care to rural Veterans and improving those individuals' access to care.

The FY 2015–2019 ORH strategic plan will be re-evaluated annually to determine if additional initiatives or actions are needed. During FY 2019, ORH will draft a new strategic plan based on its evaluation of the success of past projects undertaken to date and updated assessments of the health care needs of Veterans residing in rural areas.

S. 1434—TO DESIGNATE THE JUNCTION CITY COMMUNITY-BASED OUTPATIENT CLINIC AS THE LIEUTENANT GENERAL RICHARD J. SEITZ COMMUNITY-BASED OUTPATIENT CLINIC

S. 1434 would designate the Junction City Community-Based Outpatient Clinic located at 715 Southwind Drive, Junction City, Kansas, as the “Lieutenant General Richard J. Seitz Community-Based Outpatient Clinic.” VA defers to Congress in the naming of this facility.

S. 1471—ALICIA DAWN KOEHL RESPECT FOR NATIONAL CEMETERIES ACT

Section 2 of S. 1471, the “Alicia Dawn Koehl Respect for National Cemeteries Act,” would authorize the Secretary of Veterans Affairs and the Secretary of the Army to reconsider a decision to inter the remains or honor the memory of a person in a NCA national cemetery or in Arlington National Cemetery, respectively, when the appropriate Federal official receives information that the person may have committed a Federal capital crime or State capital crime but had not been convicted of such crime by reason of such person not being available for trial due to death or flight to avoid prosecution.

If the appropriate Federal official finds, based on a showing of clear and convincing evidence and after an opportunity for a hearing in a manner prescribed by the appropriate Federal official, that the person committed a Federal capital crime or a State capital crime but was not convicted of such crime by reason of not being available for trial due to death or flight to avoid prosecution, section 2 would require the official to notify appropriate survivors and provide an opportunity to appeal the decision to disinter the remains or remove the memorial headstone or marker.

Regarding VA, when a decision to disinter remains or remove a memorial headstone or marker becomes final by either failure to appeal the decision or by a decision of the Board of Veterans' Appeals (BVA or Board) upholding the decision, VA would have the authority to: (1) disinter the person's remains from a VA national cemetery and provide for reburial or other appropriate disposition of the disinterred remains in a place other than in a VA national cemetery or in Arlington National Cemetery; and (2) remove a Government-furnished memorial headstone or marker.

The authority for reconsideration would apply to any interment or memorialization conducted by the Secretary of Veterans Affairs or the Secretary of the Army in a VA national cemetery or in Arlington National Cemetery after the date of enactment of the Act. VA supports section 2 of this legislation.

Section 3 of the bill would require the Secretary of Veterans Affairs to disinter the remains of Michael LaShawn Anderson from Fort Custer National Cemetery. VA would be required to notify Mr. Anderson's next-of-kin of record of the impending disinterment of his remains and upon disinterment relinquish his remains to the next-of-kin of record or arrange for an appropriate disposition of the remains if the next-of-kin of record is unavailable.

Section 2 of S. 1471 would not authorize VA to reconsider a decision if an individual was convicted of a Federal or State capital crime or convicted of a Tier III sex-offense and VA had not received prior written notice of the conviction. VA would support closing this gap and will be glad to work with the Committee to provide technical assistance to effect broadening the scope of the legislation. Regarding the portions of section 2 which apply to the Department of the Army, we defer to that Department's views on this bill.

VA has another technical concern regarding the bill language in proposed section 2411(d)(4)(B) that states, "A notice of disagreement filed with the Secretary under subparagraph (A) shall be treated as a notice of disagreement filed with BVA under chapter 71 of this title, and shall be decided by the BVA in accordance with the provisions of that chapter." The language is problematic because notices of disagreement are not filed "with the Board" under chapter 71. Under section 7105(b)(1) of title 38, United States Code, notices of disagreement are filed "with the activity that entered the determination with which disagreement is expressed." Thus, the language "with the Board of Veterans' Appeals under chapter 71" should be changed to "under section 7105."

VA will provide a cost estimate for S. 1471 for the record at a later date.

S. 1547—VETERANS DIALYSIS PILOT PROGRAM REVIEW ACT OF 2013

If enacted, S. 1547 would prohibit VA from expanding VA's dialysis pilot program to facilities other than the four participating outpatient facilities until after VA has implemented the pilot program at each facility for at least 2 years, VA has provided for an independent analysis of the pilot program at each facility, and a report to Congress has been submitted. The report must address any recommendations from the Government Accountability Office (GAO) with respect to the pilot.

This bill would have the effect of prohibiting VA from activating any additional free-standing dialysis centers until at least July 2015 because one of the pilot facilities (in Cleveland, Ohio) was not activated until July 2013. VA supports using the results from the dialysis pilot to help inform future decisions on delivering care. VA would be glad to work with the Committee to ensure the Committee is briefed on the results of the pilot program before establishing any new free-standing dialysis clinics. VA is concerned that enactment of this bill in its current form would delay activating additional VA free-standing dialysis centers that could adversely impact VA's efforts to optimize Veterans' dialysis care.

An independent review of two of the pilot facilities (Raleigh and Fayetteville, North Carolina) has already been conducted by the University of Michigan Kidney Epidemiology and Cost Center, and VA has responded to, and concurred in, the five recommendations identified in the GAO report on the VA Dialysis Pilot issued in May 2012.

S. 1558—A BILL TO REQUIRE THE SECRETARY OF VETERANS AFFAIRS TO CARRY OUT A PROGRAM OF OUTREACH FOR VETERANS

S. 1558, the "Veterans Outreach Enhancement Act of 2013," would require VA to establish a five-year program for the purpose of increasing Veterans' use of the range of Federal, State, and local programs that provide compensation or other benefits, as well as increasing Veterans' awareness of such programs and their eligibility. VA would have authority to enter into agreements with Federal and State agencies to further the purposes of the program. VA also would have authority to enter into agreements with certain named regional authorities and commissions to provide technical assistance, award grants, enter into contracts, or otherwise provide amounts to persons or entities for projects that accomplish specifically enumerated purposes. The bill also would require within 4 years a comprehensive report to Congress on VA's outreach activities.

VA appreciates and shares the Committee's interest in expanding outreach activities through collaborative agreements and partnerships and is very supportive of the concept and purpose of this legislation. As detailed below, VA currently has a

number of agreements and programs with similar aims as this bill. Unless Congress provides additional funds to support S. 1558, however, entering into the grants and contracts envisioned by the bill would require offsets from funding for existing programs. We therefore are concerned about the impact on the legislation on existing VA outreach programs.

Section 2(d)(1) of S. 1558 would allow VA to “enter into agreements with other Federal and State agencies to carry out projects under the jurisdiction of such agencies to further the purpose” of the bill. VA is continually seeking to improve our collaboration and coordination with State, local, and tribal agencies to increase awareness and access to VA benefits and services. VA has existing agreements regarding outreach to Veterans with DOD, DOL, the National Association of State Directors of Veterans Affairs, and the National Association of County Veterans Service Officers, to name a few. We believe VA already has the authority to carry out the purpose of section 2(d)(1).

Section 2(d)(2) of the bill would provide VA authority to “enter into agreements with” specifically enumerated “applicable authorities and commissions” in order “to provide technical assistance, award grants, enter into contracts, or otherwise provide amounts to persons or entities for projects and activities that” pursue specifically enumerated goals. VA certainly encourages expanded authority to further the goals of the bill. However, the language in section 2(d)(2) is ambiguous with regard to the nature and scope of the authority, and how such authority differs from the authority provided for under section 2(d)(1), apart from the entities to which each section refers. We are concerned that the authorizing language may not be specific enough to provide sufficient guidance for the creation of a grant program.

Moreover, section 2(d)(2)(D) is focused on education and outreach related to the Uniformed Services Employment and Reemployment Rights Act (USERRA), a law that falls under the jurisdiction of the Department of Labor (DOL). VA believes that any such education and outreach on USERRA should be coordinated through a Memorandum of Understanding with DOL.

Section 2(d)(3) specifically enumerates the “applicable authorities and commissions” discussed in section 2(d)(2). VA believes the funding authority should also encompass local and tribal governments. Many local and tribal governments have established Veterans agencies with which VA currently partners to conduct outreach. The ability to provide direct assistance to those governments could be a more efficient use of funds in some situations.

Section 2(e) would provide VA the authority to provide, or contract with public and private organizations to provide, information, advice, and technical assistance to nonprofit organizations. VA supports the authority provided in this subsection, but recommends expanding this authority to provide technical assistance to other entities as well. Circumstances vary by jurisdiction. We believe States may be in a better position in some instances to meet the goals of this section. Expanding the scope of this provision to encompass States would allow VA a wider range of options.

With regard to the comprehensive report on the outreach activities of VA that would be required under section 2(f), VA is already required to provide a biennial report on all VA outreach activities under section 402 of Public Law 109–233. All outreach activities associated with this legislation would be included in the outreach reports to be provided to Congress under Public Law 109–233. VA believes this additional reporting requirement is unnecessary.

VA has a strong interest in ensuring that Veterans know of the benefits they have earned—the role of outreach is critical throughout the myriad missions of VHA, VBA, and NCA. We would be glad to meet with the Committee to discuss ongoing outreach efforts and the ideas represented in this bill. VA will provide its cost estimate for this bill at a later time.

S. ——— (DRAFT BILL) VETERANS HEALTH CARE ELIGIBILITY EXPANSION AND
ENHANCEMENT ACT OF 2013

The draft bill would expand eligibility for VA health care. While VA understands the intent behind expanding eligibility and enhancing services for Veterans. However, before providing definitive views, VA must carefully consider the implications of each provision of this bill, including the cost for such expansion and the impact upon existing eligible populations. VA received the text of this bill on October 11, 2013 and is continuing this analysis. VA will provide a more detailed response that will specifically address each provision—including cost information—within a short time of this hearing.

Section 2 of the bill would amend 38 U.S.C. 1710(a)(3) by replacing “may, to the extent resources and facilities are available,” with “shall.” We are evaluating the im-

pect of this proposed change, particularly as it pertains to section 1705, which specifies how the Secretary is to manage the system of patient enrollment.”

Section 3 of the bill would add a new subsection to 38 U.S.C. 1705 which would require the Secretary to provide for the enrollment of certain veterans who are unable to enroll in the VA health care system as of the date of the enactment of the bill and who do not have access to health insurance except through a health exchange established pursuant to section 1311 of the Affordable Care Act. Section 3 would require VA to work with HHS and the Department of Treasury to access information regarding the “access to healthcare” via the exchanges.

Section 3 of the bill presents many potential complications and uncertain effects on VA’s enrollment system, as well as issues that will require detailed consultation with HHS and the Department of Treasury. We will address issues concerning section 3 in a more detailed response to the Committee.

Section 4 of the bill would expand the combat eligibility provision in 38 U.S.C. 1710(e)(1)(D) for Veterans discharged after January 28, 2003, from 5 years from the date of the Veteran’s discharge to 10 years. Section 4 would also extend eligibility for Veterans who were discharged before January 28, 2003 until January 27, 2018. VA supports the intent of section 4 of the bill but would be interested in further discussion on other options to expand access to Combat Veterans.

Section 6 of the bill would require VA and the Secretary of Health and Human Services to carry out the “Medicare VA reimbursement program” wherein HHS would reimburse VA for certain health care furnished to Medicare-eligible Veterans. Section 7 of the bill would direct VA to make certain modifications for purposes of determining whether veterans qualify for treatment as low income families for enrollment under 38 U.S.C. 1705(a)(7). Section 8 of the bill would require VA to use the capitation-based resource allocation model in entering into contracts for the furnishing of health care services.

From our preliminary review to date, VA has particular concerns with Sections 6, 7 and 8 of this bill, and needs additional time to fully study the impact on existing business infrastructure, billing systems, and net Federal costs. In regards to section 6, VA needs additional time to fully understand the impact of obtaining Medicare reimbursement, which will require consultation with HHS. VA expects there will be costs to set up the infrastructure for billing Medicare, as well as new benefit costs to the Medicare program. Section 7 is technically feasible, but requires further investigation to ensure it represents an equitable approach to expanding health care eligibility for low-income Veterans. Section 8 would be challenging because it would change the payment structure for non-VA medical care.

Mr. Chairman, as noted above, we are working diligently to provide fuller analysis and notes on anticipated costs shortly after this hearing. As you know, we have had the opportunity to discuss the critical subject of access to health care for Veterans with you and Committee staff prior to receiving the text of this bill. We look forward to continuing those discussions.

S.— (DRAFT BILL) REGARDING THE SERVICE-DISABLED VETERANS INSURANCE PROGRAM

The draft bill would update the Service-Disabled Veterans Insurance (S-DVI) program by amending section 1922(a) of title 38, United States Code, to base premium rates on the 2001 Commissioners Standard Ordinary (CSO) Mortality Table instead of the 1941 CSO Mortality Table currently used in that program.

VA supports the intent of this draft bill to change the mortality basis of the S-DVI program, provided Congress finds corresponding funding offsets. The S-DVI program was intended to enable service-disabled Veterans to purchase insurance coverage at “standard” premium rates. Currently, S-DVI premiums are based on an old mortality table, i.e., the 1941 CSO Mortality Table, with 2.25 percent interest. In 1951, when this program began, these premium rates were competitive with commercial insurance policy rates. However, because life expectancy has significantly lengthened over the past 50 years, a more recent mortality table would reflect lower mortality and, hence, lower premium rates.

The draft bill would base S-DVI premiums on the 2001 CSO Mortality Table, which is the current mortality standard in the commercial insurance industry. This would result in significantly lower premium costs for service-connected disabled Veterans. As a result, VA could see a greater number of such Veterans applying for S-DVI coverage, thereby enhancing financial security for them and their families. Further, because this draft bill would also reduce premiums for current policyholders, it would allow both new and current policyholders who are paying premiums to use funds they currently expend on their S-DVI premiums for other purposes. Approximately 60 percent of current policyholders have their premiums

waived because they have been determined to be "totally disabled." A comparison conducted by VA of current premium rates with those that would be charged shows that premiums would be dramatically reduced for some individuals, and all policyholders would see their premiums significantly reduced.

VA recommends that the bill be amended to also change the interest rate basis from 2.25 percent to 3 percent. Current economic indicators suggest that 3 percent more accurately reflects a realistic long-term interest rate for this program. Changing the basis to 3 percent would further lower the premium rates for S-DVI policyholders.

VA will provide a cost estimate for the record at a later time.

ADDITIONAL VIEWS SUBMITTED BY THE U.S. DEPARTMENT OF VETERANS AFFAIRS



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

NOV 18 2013

The Honorable Bernard Sanders
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

I am writing to provide you with the views of the Department of Veterans Affairs (VA) on the following bills: S. 1559, S. 1573, and S. 1581. These bills were included on the Senate Committee on Veterans' Affairs agenda for its October 30, 2013, hearing, but VA was unable to provide its views in time for that hearing. We are providing views and costs on the following provisions and draft bills: Sections 3-5 of S. 1155, S. 1556, S. 1581, Sections 5-7 of the Veterans Health Care Eligibility Expansion and Enhancement Act 2013 (Revised)(introduced as S. 1604), the Enhanced Dental Care for Veterans Act of 2013 (introduced as S. 1586), the Mental Health Support for Veteran Families and Caregivers Act of 2013 (introduced as S. 1583), the Medical Foster Home Act of 2013 (introduced as S. 1578), and Senator Hirono's draft bill regarding reimbursement for emergency medical treatment (introduced as S. 1588). We are also providing cost estimates for S. 1165, S. 1411, S. 1471 and S. 1558, as promised during the hearing. S. 1579 and S. 1593 would affect programs or laws administered by the Departments of Defense, Justice, Health and Human Services, Homeland Security, and Commerce. Respectfully, we defer to those Departments' views on these bills.

VA will be providing views on S. 875, S. 1296, S. 1540, S. 1556, S. 1580, S. 1582, S. 1589, S. 1602, section 4 of 1604 and costs associated with S. 1581, S. 1583, S. 1584 and S. 1586 by a subsequent letter to the Committee, and anticipates also providing further costing detail on some measures.

We appreciate the opportunity to comment on these bills and look forward to working with you and the other Committee members on these important legislative issues.

Sincerely,

Eric K. Shinseki

Enclosure

S. 1155—RURAL VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT

Section 3(a) would require VA, in carrying out the education and training program required under section 7302(a)(1) of title 38, U.S.C., to include education and training of marriage and family therapists and licensed professional mental health counselors. VA does not support section 3(a).

VA cannot offer clinical education to Licensed Professional Mental Health Counselors (LPMHC) and Marriage and Family Therapist (MFT) trainees until the following VA requirements are met:

1. *Accreditation.* The trainee's educational program must be accredited by a National Accrediting Body formally recognized by the U.S. Department of Education or the Council for Higher Education Accreditation.

2. *Affiliation Agreement.* The VA facility must have a formal Affiliation Agreement with the Educational Institution or Training Program.

3. *Supervisory Staff.* The VA training program must have sufficient qualified and experienced supervisory staff licensed or otherwise authorized to practice in VA in the same profession as the trainees.

4. *Ability to Hire Graduates.* There must be national program office agreement that the trainees in the training program would gain credentials to be hired into VA according to current qualification standards for the discipline.

5. *Administrative Infrastructure.* There must be sufficient administrative infrastructure, including staff support, space, and information technology equipment.

6. *Patient Population.* There must be a sufficient and appropriate patient population to meet curricular goals for the training program.

Within several years, it is likely that VA will include the education and training of LPMHCs and MFTs in the health professions trainee program conducted under the authority in section 7302, thereby satisfying the intent of section (a). However, VA is not currently positioned to address many of the requirements enumerated above. For example, VA does not yet have an affiliated training partner, adequate supervisory staff or administrative infrastructure to support such a program.

Section 3(b) would require VA to apportion funding for the education and training program equally among the professions included in the program. The text in section 3(b) is of serious concern to VA, and thus we do not support the provision. The creation of a VA-paid stipend program for LPMHC and MFT master's degree students is a different process from local development of an affiliation agreement to offer clinical training to "without compensation trainees." Individual medical centers do not have authority to offer stipends for clinical training. All stipends for clinical trainees are authorized at the national level and paid for by centralized funds. The decision to offer stipends to a particular discipline is made at the national level by program offices after consultation with national leadership governance bodies.

Once stipends are authorized nationally, trainee positions are then competitively offered to VA facilities that wish to participate. The decision to authorize stipends for trainees is based on several criteria, including the following: (1) whether VA is having difficulty recruiting professionals in the discipline in question; (2) whether funding is available for these new trainee stipends or can the funding be redirected from other already established training programs; and (3) the standards in the health care community regarding stipends for trainees of the discipline. Veterans Health Administration (VHA) Office of Academic Affiliations works closely with VHA's Workforce Talent Management Office to track recruitment demand that might warrant a funded training program.

VHA must retain funding flexibility across all health professions trainee programs. A bill requiring "equal funding across professions" would significantly diminish VHA's ability to implement changes to the health professions trainee programs based on emerging Veteran needs.

Cost estimates cannot be provided for section 3. There is no cost for allowing Without Compensation (WOC) trainees to rotate through VA as long as the criteria for training programs are met (see above). However, in this instance, where the criteria for training LPMHCs and MFTs are not yet met, funding for training LPMHCs and MFTs would be considerably distant and therefore not easily determined at this time. VHA would need extensive experience with the WOC trainees before a request for authorization of stipends could be properly evaluated and approved.

We believe that section 4 of S. 1155 contains a drafting error, and that it is intended to amend section 304 of Public Law (P.L.) 111-163, as amended by section 730 of Public Law 112-239, which added a new subsection (e) to section 304. If this understanding is correct, VA believes the net effect of amendments would be as follows. Peer outreach and peer support services would continue to be provided to the Veterans specified in section 304 pursuant to subsections 304(a)(1)(A) and (B).

Under new subsection (e)(2), VA would be required to carry out the services in subsection (a)(2) of section 304 at or through VA medical centers.

It is not clear whether adding subsection (e)(2) to section 304 is intended to clarify or change the provision of mental health services to the immediate family members of these Veterans. We note that the language, “at or through Department medical centers” would authorize VHA to provide those mental health services described in subsection (a)(2) at VA medical centers, community based outpatient clinics (CBOCs) or by use of contracts. We would welcome the opportunity to discuss this provision with the Committee.

Because the impact of this section is unclear, we cannot provide a cost estimate at this time.

Section 5 of S. 1155 would require the Secretary to submit a report to Congress not later than 120 days after the date of enactment of the Act that addresses the following:

- Issues that may be impeding the provision of telemedicine services for Veterans, including the following:
 - Statutory or regulatory restrictions
 - Licensure or credentialing issues for any provider practicing telemedicine with veterans who live in a different State than the provider
 - Limited broadband access in rural areas
 - Limited information technology resources or capabilities
 - Long distances veterans must travel to access a facility or clinic with telemedicine capabilities
 - Insufficient liability protection for providers
 - Reimbursement issues faced by providers
 - Travel limitations for providers that are unaffiliated with VA and are participating or seeking to participate in a VA telemedicine program
- Actions taken to address the issues identified above
- An update on efforts to carry out the initiative of teleconsultation for the provision of remote mental health and Traumatic Brain Injury assessments required by 38 U.S.C. 1709A
- An update on efforts to offer training opportunities in telemedicine to medical residents, as required by section 108(b) of Public Law 112–154, codified at 38 U.S.C. 7406, note
- An update on efforts, in partnership with primary care providers, to install video cameras and instruments to monitor weight, blood pressure, and other vital statistics in the homes of patients.

Section 5 would also define “telemedicine” as the use by a health care provider of telecommunications to assist in the diagnosis or treatment of a patient’s medical condition.

VA has no objection to reporting on the content specified in sections 5(a)(1)(E) (the distances a Veteran must travel to access a telemedicine-equipped facility), 5(a)(3) (certain teleconsultation initiatives) and 5(a)(4) (residents telemedicine training) of this bill. The provisions are straightforward.

VA does not support reporting on the content specified in section 5(a)(1)(A) (statutory and regulatory restrictions) because it is unnecessary and duplicative of recent efforts. VA and Department of Defense (DOD) already collaborate and share information about the provision of telehealth services to Veterans and Servicemembers. VA does not support providing a report related to the content specified in sections 5(a)(1)(B) (licensure and credentialing and privileging issues), 5(a)(1)(F) (insufficient liability protection issues), 5(a)(1)(G) (provider reimbursement issues) and 5(a)(1)(H) (travel limitations for providers). VA does not believe these issues impact or impede VA providers or VA’s ability to provide telehealth services and so these are not areas we believe appropriate for a reporting requirement. VA would welcome discussion with the Committee if there are differing perceptions regarding those issues.

VA seeks clarification on what is meant by “limited” broadband access in rural areas and “limited” information technology resources or capabilities in sections 5(a)(1)(C) and (D).

VA does not anticipate that section 5 would result in any additional costs.

S. 1165—ACCESS TO APPROPRIATE IMMUNIZATIONS FOR VETERANS ACT OF 2013

S. 1165 would amend section 1701 of title 38, U.S.C., to include certain adult immunizations as part of the preventive services detailed in subsection 9 of the statute. The bill would also amend section 1706 of title 38, U.S.C., to require VA to develop quality measures and metrics to ensure that Veterans receiving medical services also receive the immunizations. As discussed in VA’s October 30, 2013 testi-

mony, VA strongly supports preventive care measures, but does not support this legislation because VA is already satisfying the intent of this bill.

VA estimates the costs associated with enactment of developing and implementing quality measures in S. 1165 to be as follows: \$639,188 in FY 2014; \$3.24 million over 5 years; and \$6.6 million over 10 years.

S. 1411—RURAL VETERANS HEALTH CARE IMPROVEMENT ACT OF 2013

S. 1411, Rural Veterans Health Care Improvement Act of 2013 (the “Act”), would direct the Department to apply specified consultation, information, and transmittal requirements when issuing VHA’s planned update of the FY 2010–2014 Strategic Plan of the VHA Office of Rural Health (ORH). For the reasons stated in VA’s October 30, 2013 testimony, VA does not support S. 1411.

VA estimates the costs associated with enactment of S. 1411 to be as follows: \$323,808 for FY 2013; \$930,842 over a 5 year period; and \$1,943,545 over a 10 year period.

S. 1471—ALICIA DAWN KOEHL RESPECT FOR NATIONAL CEMETERIES ACT

Section 2 of S. 1471 would authorize the Secretary of Veterans Affairs and the Secretary of the Army to reconsider a decision to inter the remains or honor the memory of a person in a cemetery in the National Cemetery Administration or in Arlington National Cemetery, respectively, when the appropriate Federal official receives information that the person may have committed a Federal capital crime or State capital crime but had not been convicted of such crime by reason of such person not being available for trial due to death or flight to avoid prosecution.

If the appropriate Federal official finds, based on a showing of clear and convincing evidence and after an opportunity for a hearing in a manner prescribed by the appropriate Federal official, that the person committed a Federal capital crime or a State capital crime but was not convicted of such crime by reason of not being available for trial due to death or flight to avoid prosecution, section 2 would require the official to notify appropriate survivors and provide an opportunity to appeal the decision to disinter the remains or remove the memorial headstone or marker.

Section 3 of the bill would require the Secretary of Veterans Affairs to disinter the remains of Michael LaShawn Anderson from Fort Custer National Cemetery. VA would be required to notify Mr. Anderson’s next-of-kin of record of the impending disinterment of his remains and upon disinterment relinquish his remains to the next-of-kin of record or arrange for an appropriate disposition of the remains if the next-of-kin of record is unavailable. VA provided views for this bill at the October 30, 2013, hearing.

VA estimates that there would be no significant costs or savings associated with enactment of section 2 of S. 1471 because situations where the authority provided by this bill would be needed would be uncommon and VA does not anticipate a significant increase in such cases.

S. 1558—VETERANS OUTREACH ENHANCEMENT ACT OF 2013

S. 1558 would require VA to establish a 5 year program for the purpose of increasing Veterans’ use of the range of Federal, State, and local programs that provide compensation or other benefits, as well as increasing Veterans’ awareness of such programs and their eligibility. VA would have authority to enter into agreements with Federal and State agencies to further the purposes of the program. VA also would have authority to enter into agreements with certain named regional authorities and commissions to provide technical assistance, award grants, enter into contracts, or otherwise provide amounts to persons or entities for projects that accomplish specifically enumerated purposes. The bill also would require within four years a comprehensive report to Congress on VA’s outreach activities.

VA is unable to estimate the costs that would be associated with enactment of this bill at this time. S. 1558 would authorize \$7 million for FY 2014 and \$35 million for FY 2015 through FY 2019 to carry out the program that this bill would authorize. The actual costs would depend on the extent that VA utilizes the authorities established in the bill to carry out the required outreach program.

S. 1559—BENEFITS FAIRNESS FOR FILIPINO VETERANS ACT OF 2013

S. 1559 would amend section 107(c) of title 38, U.S.C., to prohibit the Secretary of Veterans Affairs from determining that a World War II Filipino Veteran is not an individual residing in the United States for purposes of that subsection solely because the person is outside the United States for any period of time less than one year. Under this bill, certain Filipino Veterans would be considered residents of the

United States when they are outside of the United States for any period of time less than one year and therefore would be eligible for full-dollar rate of benefits under section 107(a) or (b).

Section 107 authorizes certain Veterans benefits for World War II Filipino Veterans with qualifying service and their survivors. These benefits are paid at half of the full rate of payment, except for individuals “residing in the United States” who are also either a U.S. citizen or an alien lawfully admitted for permanent residence in the United States. Section 1734 of title 38, U.S.C., requires the same residency and citizenship or alien status for otherwise eligible World War II Filipino Veterans to be eligible for hospital and nursing home care and medical services in the United States.

VA does not support S. 1559 because VA has already promulgated regulations that utilize objective and reasonable criteria for determining whether an individual meets the requirement of “residing in the United States” for purposes of receiving benefits at the full-dollar rate for World War II Filipino Veterans and their survivors. Under existing VA regulations at 38 CFR 3.42(d)(1), “to continue receiving benefits at the full-dollar rate * * *, a veteran or a veteran’s survivor must be physically present in the [United States] for at least 183 days of each calendar year in which he or she receives payments at the full-dollar rate, and may not be absent from the [United States] for more than 60 consecutive days at a time unless good cause is shown.”

When VA promulgated these regulations, VA explained that “Congress did not intend to create a windfall for Filipino Veterans who do not actually face the higher cost of living in the [United States]” and that, “[i]n order to avoid that potential result, Congress required that Filipino Veterans be residing in the [United States] and either be citizens of the [United States] or aliens lawfully admitted for permanent residence in the [United States].” Filipino Veterans’ Benefits Improvements, 66 Fed. Reg. 66,763 (Dec. 27, 2001). VA reasoned that “[i]f a veteran is absent from the [United States] for longer than these periods, it is reasonable to conclude that he or she is not residing in the [United States] * * *. This rule will also allow veterans reasonable periods to travel outside of the [United States] for business or personal reasons without having their benefits reduced.” *Id.* VA reasonably tailored its regulations to ensure that full-dollar-rate benefits are paid to those Filipino Veterans who maintain U.S. residency and face the higher costs of living in the United States. Further, the regulations allow resumption of payments at the full-dollar rate upon restored eligibility. This approach provides flexibility for beneficiaries and is consistent with the adjustments made to compensation awards based on other changes in beneficiary status. Because S. 1559 would likely result in payment of full-dollar-rate benefits to persons who do not reside in the United States, VA does not support this bill.

S. 1573—MILITARY FAMILY RELIEF ACT

Section 2(a) and (b) of S. 1573 would amend sections 1318 and 1541 of title 38, U.S.C., to establish in VA’s dependency and indemnity compensation (DIC) and pension programs a temporary 6 month benefit, which VA would pay to an individual determined by the Secretary based on evidence in a qualified deceased Veteran’s file on the date of his or her death to be the deceased Veteran’s surviving spouse, without that individual having to submit a claim for such benefits. For the temporary DIC award, the Veteran would have to have been, at the time of death, in receipt of or entitled to receive (or but for the receipt of retired or retirement pay entitled to receive) compensation for a service-connected disability continuously rated totally disabling for not less than one year immediately preceding death. For the temporary pension award, the Veteran would have to have been, at the time of death, in receipt of pension under section 1513 or 1521 of title 38, U.S.C., as a married Veteran based on the Veteran’s marriage to the individual. Section 2(c) would make a conforming amendment to section 5101(a)(1) of title 38, U.S.C., to reference possible exceptions, as may be provided in title 38, U.S.C., to the present requirement for a “specific claim in the form prescribed by the Secretary” as a prerequisite to benefit entitlement.

VA supports S. 1573, provided Congress finds corresponding funding offsets. By authorizing VA to pay for 6 months following the Veteran’s death DIC or pension to the Veteran’s surviving spouse based on the Veteran’s pre-existing disability ratings and dependent information in VA systems on the date of the Veteran’s death, and by expressly eliminating the claim requirement, the bill would enable VA to automate payments and quickly pay the surviving spouse during a difficult period of transition and while VA is processing any other benefit claims that the surviving spouse may have filed. These temporary awards would be for transitional purposes

only. Surviving spouses would still have to apply for DIC or survivors' pension to continue benefit payments beyond the six-month period prescribed in the bill.

VA estimates the benefit costs of enactment of S. 1573 would be \$58.2 million in FY 2015, \$332.6 million over 5 years, and \$759.8 million over 10 years. VA estimates no additional general operating expenses associated with enactment of this bill because the bill would permit automated payments based on data within VA systems. Therefore, no additional claim development resources would be required.

S. 1576—TO REDESIGNATE THE DEPARTMENT OF VETERANS AFFAIRS HEALTHCARE SYSTEM LOCATED AT 10000 BAY PINES BOULEVARD AS THE “C.W. BILL YOUNG DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER”

S. 1576 would re-designate the Department of Veterans Affairs Healthcare System located at 10000 Bay Pines Boulevard as the “C.W. Bill Young Department of Veterans Affairs Medical Center.” VA defers to Congress on the naming of this facility.

S. 1578—MEDICAL FOSTER HOME ACT OF 2013

S. 1578 would authorize VA, in conducting the medical foster home program pursuant to 38 CFR 17.73, to cover the costs of care of Veterans in a VA-approved Medical Foster Home. Section 17.73 defines “medical foster home” to mean a private home in which a medical foster home caregiver provides care to a Veteran resident, the caregiver lives in the home and owns or rents the home, and there are not more than three residents receiving care. These homes must meet VA standards set forth in 38 CFR 17.74. To be eligible for the program, the Veteran must be unable to live independently safely or be in need of nursing home level care and agree to receive care in certain VA programs designed to assist medically complex Veterans living at home. VA supports enactment of this bill, particularly given the cost savings as compared to paying for nursing home care.

If this bill is enacted, VA estimates cost savings will result as follows: \$57.62 million in FY 2014; \$415.89 million over 5 years; and \$1.39 billion over 10 years. These costs are consistent with those estimated in the FY 2014 President's Budget.

S. 1579—SCRA ENHANCEMENT AND IMPROVEMENT ACT OF 2013

S. 1579 would amend the Servicemembers Civil Relief Act (50 U.S.C. App. 501, et seq.) to expand protections for servicemembers and their families under that act with respect to installment contracts, mortgages, professional licenses, taxes, and credit and seek to improve provisions relating to enforcement. This bill has little effect on VA programs. This bill would largely affect issues relating to current members of the uniformed services and consequently is primarily of concern to DOD, Homeland Security, Health and Human Services, and Commerce. The bill would further relate to matters of Department of Justice enforcement. Accordingly, we defer to those departments' views on this bill.

S. 1581—SURVIVORS OF MILITARY SEXUAL ASSAULT AND DOMESTIC ABUSE ACT OF 2013

Section 2 of the bill would expand VA's authorization to provide counseling and care needed to recover from experiences of military sexual trauma (MST) to include active duty Servicemembers as well as Veterans. Section 2 would also specify that eligible members of the Armed Forces would not be required to obtain a referral to access these services. VA has significant expertise in treating MST-related health conditions and believes that expanding authorization to include Servicemembers would benefit this population. VA supports the goals of this provision but has concerns about the costs and additional staffing that could be required if the bill is enacted. We also recommend the Committee solicit input from the DOD.

We note that VA and the draft bill define MST to include sexual assault and sexual harassment experienced during military service. Thus, VA believes the bill may be more appropriately named the “Survivors of Military Sexual Trauma and Domestic Abuse Act of 2013.”

VA currently provides MST-related care free of charge to eligible Veterans. Under current law, VA may provide care (including MST-related care) to Servicemembers, but VA must recover the cost of that care. The bill would require VA to develop a national infrastructure for tracking MST-related care provided to Servicemembers, and VA and DOD would need to collaborate to develop monitoring and other processes related to eligibility, billing and care coordination. The bill would also greatly expand the work of VA's MST Coordinators. VA is still analyzing this provision and will provide costs upon completion of this work. VA assumes section 2 would require VA to recover the cost of providing MST-related care to Servicemembers from DOD.

Section 3 of the draft bill would require, not later than 540 days after the date of the bill's enactment, that the Secretary of Veterans Affairs develop and implement a screening mechanism by which to detect if a veteran seeking VA health care services has been a victim of domestic abuse. It would require such information to be used to improve the treatment of the veteran and to assess the prevalence of domestic abuse in the veteran-population. The draft bill would set forth a broad definition of "domestic abuse" for purposes of this section. Specifically, that term would mean:

(1) Behavior with respect to an individual that constitutes a pattern of behavior resulting in physical or emotional abuse, economic control, or interference with the personal liberties of that individual; or a violation of Federal or State law involving the use, attempted use, or threatened use of force or violence against that individual; or a violation of a lawful order issued for the protection of that individual; and

(2) Is committed by a person who is a current or former spouse or domestic partner of that individual; shares a child in common with that individual; is a current or former intimate partner of that individual that shares or has shared a common domicile with that individual; is a caregiver of that individual as defined by 38 U.S.C. 1720G(d); or is in any other type of relationship with that individual that the Secretary may specify for purposes of this section.

VA supports section 3 of the bill. The Center for Disease Control defines intimate partner violence (IPV) as actual or threatened physical, sexual, or psychological harm or stalking behavior by an intimate partner that may vary in frequency and severity (Saltzman, Fanslow, McMahon, & Shelley, 1999). Research indicates higher rates of these incidents for women Veterans, and that these are likely underestimated because of underreporting. Research has also shown the relationship between IPV and poor medical and mental health outcomes. Most major medical organizations, including the Institutes of Medicine, recommend routine screening for IPV.

VA is uniquely poised to implement universal screening and coordinate provision of appropriate referrals and intervention for IPV among women Veterans, given its strong track record of universal screening and integrated primary and mental health follow-up care for depression, Post Traumatic Stress Disorder, and MST. VA supports establishing MST screening for all Veterans, but we note that research is lacking on the best strategies for screening for male patients. Therefore VA's screening efforts would focus initially on intimate partner violence for women Veterans, while strategies for MST screening for male Veterans are being further studied.

Section 4 would require VA to submit a report to Congress on the treatment and services available for male veterans who experience MST (as defined by 38 U.S.C. 1720D) as compared to that available for female Veterans. This report would be due not later than one year after the date of enactment of this Act. That report would also have to include a detailed report on domestic abuse among veterans that address all of the specified reporting elements set forth in that section. Section 4 would also establish a detailed reporting requirement for the VA/DOD Joint Executive Committee (JEC) (commencing not later than one year after the date of the Act's enactment and annually thereafter for 5 years) that identifies the processes and procedures used to facilitate the transition of individuals receiving treatment for MST and domestic abuse from DOD's health care system to VA's. The JEC report would also have to describe and assess the collaboration between VA and DOD in assisting Veterans file disability claims related to MST or domestic abuse including permitting Veterans access to information and evidence necessary to develop or support such claims.

With respect to section 4(a) of the bill (requiring a report on the treatment and services available for male veterans who experience MST), VA supports this requirement but believes it would require a comprehensive data collection effort to ensure an adequate assessment is accomplished. VA is working to develop this cost estimate and will provide to the Committee as soon as it is available.

Regarding section 4(c)(2), VA does not object to providing future reports with a "description and assessment" of the ongoing collaboration between VA and DOD "in assisting veterans in filing claims for disabilities related to military sexual trauma or domestic abuse, including permitting veterans access to information and evidence necessary to develop or support such claims." However, although VA does not object to providing such reports, it is unclear why such a reporting requirement is necessary. Collaboration between VA and DOD already exists as a significant element in the adjudication process of MST claims and is not likely to change considerably in the future. Furthermore, VA is already required under 38 U.S.C. 5103 to inform claimants about what information or evidence, whether military or non-military, is needed to substantiate their claims. In addition, VA has a statutory obligation

under 38 U.S.C. 5103A to “make reasonable efforts to assist a claimant in obtaining evidence necessary to substantiate the claimant’s claim for a benefit under a law administered by the Secretary.” Veterans have access to their own VA disability claim files, and the Freedom of Information Act and Privacy Act provide additional avenues to procure information and evidence maintained by Government entities.

VA estimates that costs associated with section 4(c)(2) would not be significant because VA does not anticipate changes to established procedures. However, preparing the reports would entail a cost and would divert resources from addressing the disability claims backlog.

S. 1583—MENTAL HEALTH SUPPORT FOR VETERAN FAMILIES AND
CAREGIVERS ACT OF 2013

S. 1583 would require the Secretary, not later than 270 days after enactment, to establish an education program and a peer support program for the education and training of family members and caregivers of enrolled Veterans with mental health disorders. Under the education program and the peer support program, the Secretary would provide a course of education peer support, respectively, to family members and caregivers of eligible Veterans on matters relating to coping with mental health disorders in Veterans.

The education program would be carried out for four years and could be extended by the Secretary for an additional four-year period. The program would initially be carried out in not less than 10 VA medical centers, not less than 10 VA clinics, and not less than 10 Vet Centers, with consideration given to selecting locations in rural areas, areas not in close proximity to an active duty installation, and areas in different geographic locations. Not later than 2 years after commencement, the Secretary would be required to expand the number of facilities at which the program is carried out to additional VA medical centers, VA clinics, and Vet Centers. In carrying out the program, the Secretary would be required to enter into contracts with qualified non-profit entities to offer the course of education. Such entities would have experience in mental health education and outreach, including work with children, teens, and young adults, and would meet other specified criteria. Priority would be given to qualified entities that use Internet technology for the delivery of course content in an effort to expand availability of support services, especially in rural areas. The course of education would consist of not less than 10 weeks of education and include specified elements. Instructors would be required to maintain a level of proficiency as determined by the Secretary and submit proof of such proficiency as the Secretary determines appropriate. VA mental health care providers would be selected by the Secretary to monitor, in consultation with primary care providers, the progress of the instruction by meeting quarterly with instructors. Each VA mental health care provider selected would be required to submit a progress report to the Secretary not less frequently than semiannually.

The Secretary would provide peer support under the peer support program at each location where education is provided under the education program. Peer support would consist of meetings in group settings between a peer support coordinator and family members and caregivers; the meetings would be conducted not less than twice each calendar quarter. Peer support coordinators would be selected among individuals who successfully completed the course of education, and would maintain a level of proficiency as determined by the Secretary and submit proof of such proficiency as the Secretary determines appropriate. A VA mental health provider would be selected by the Secretary to serve as a mentor to each peer support coordinator. VA mental health providers selected to monitor instruction under the education program would monitor the progress of the peer support program by meeting quarterly with peer support coordinators, and would be required to submit a progress report to the Secretary not less frequently than semiannually.

The Secretary would be required to conduct a comprehensive and statistically significant survey of the satisfaction of individuals that have participated in the course of education and individuals that have participated in the peer support program. Not later than one year after commencement of the education program and by September 30 each year thereafter until 2017, the Secretary would be required to submit a report on the education program and peer support program to the Committees on Veterans’ Affairs of the Senate and the House of Representatives. Each annual report would include specified elements, including information compiled as a result of the surveys. Not later than one year after completion of the education program, the Secretary would be required to submit to the Committees on Veterans’ Affairs of the Senate and the House of Representatives a report on the feasibility and advisability of continuing the education program and the peer support program, including specified elements.

VA applauds the Committee's attention to the important topic of support for family members and caregivers of Veterans. However, because we believe VA's programs now fulfill the goals of the bill, we do not support S. 1583. VA is already engaged in multiple programs to educate and support family members and caregivers of Veterans from all eras with a mental health disorder. For example, VA's Family-to-Family Education Program (FFEP) was established in partnership with a non-profit entity, the National Alliance on Mental Illness (NAMI), to provide an education program and peer support program for the education and training of eligible family members and caregivers of Veterans with a mental health disorder. The FFEP consists of a 12-week program and includes general education on different mental health disorders, techniques for handling crisis situations, techniques for coping with individuals suffering from mental health disorders, and information on resources. NAMI FFEP teachers are peer-instructors who have personal experience in successfully coping with family problems and who complete 3.5 days of training. During the period of December 2010–2013, the education program was implemented in 84 VA facilities, including CBOC and rural sites. FFEP is a remarkably successful peer program and is built around the values of inclusion and empowerment for everyone concerned. Research on FFEP outcomes has shown an increase in empowerment, knowledge about mental illness and problem solving skills, and a decrease in general anxiety.

Other collaborations include VA's partnership with the National Council on Aging, through which VA provides Building Better Caregivers/TM—a web-based online training and support workshop for eligible family caregivers of Veterans of all eras. To date, more than 1,500 family caregivers of Veterans have been referred to the 6-week program. This training provides specific content for family caregivers of Veterans and is facilitated by family caregivers.

Other VA programs also facilitate education and support of eligible family members and caregivers of Veterans with a mental health disorder, including under the Continuum of Mental Health Services (MHS), VA's Caregiver Support Program, and the Readjustment Counseling Service.

VA's MHS offers eligible family members and caregivers Veteran-Centered Brief Family Consultation, Family Psychoeducation (Behavioral Family Therapy and Multiple Family Group Therapy), and several different models of Marriage and Family Counseling. MHS has also nationally disseminated two clinician-led family education models for individuals with mental health conditions—Support and Family Education (SAFE), which is an 18-session program, and Operation Enduring Families, which is a 5 session program that is focused on family members of Veterans of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.

Through VA's Caregiver Peer Support Mentoring Program, approximately 150 eligible family caregivers of Veterans are engaged in peer support activities. Many of the family caregivers who serve as Caregiver Peer Support Mentors are family caregivers of Veterans with a mental health disorder. Also, in June 2012, VA's Caregiver Support Program provided a training utilizing VA's satellite broadcast network for family caregivers of Veterans with Post Traumatic Stress Disorder (PTSD). The training was led by a subject matter expert from VA's National Center of Excellence on PTSD and included specific training on supporting Veterans with PTSD, as well as coping techniques and skills for family caregivers. The format included a training session followed by 40 minutes for a question and answer session. The course was viewed live by more than 590 family caregivers at approximately 100 VA sites. Given its success, the Caregiver Support Program has provided additional training for family caregivers using this method including a broadcast on Traumatic Brain Injury and a broadcast on Pain Management. The broadcasts are videotaped in order for them to be provided to family caregivers who were unable to attend the broadcasts.

Additionally, Vet Centers provide readjustment counseling to family members of eligible Veterans when found to aid in the readjustment of the Veteran and can include individual, family, and group counseling, as well as psycho-education to help families understand the war-related readjustment issues, such as PTSD, that their Veterans face. As of part of the group counseling available to families, many Vet Centers make available family support groups. Vet Centers are known for their high percentage of employees who have served in the military which aid in ability to create a peer to peer or Veteran to Veteran relationship; the program also employs many family members of Veterans who bring those experiences to the clinical work that they provide. Veterans and their families who present to Vet Centers with serious mental illness are referred to VHA Medical Facilities for appropriate care.

Finally, we note that section 2(a)(2)(A) of the bill would define "family member" and "caregiver" as those terms are defined in 38 U.S.C. 1720G(d). However, the defi-

nitions of those terms in section 1720G(d) apply with respect to an eligible Veteran under section 1720G(a), (and in the definition of “caregiver” also with respect to a covered Veteran under section 1720G(b)). We believe this creates some ambiguity as to which family members and caregivers would be eligible under the bill. We therefore recommend that either section 2(a)(2)(A) of the bill be clarified to indicate that the education and peer support under the bill would be limited to family members and caregivers participating in the programs under 38 U.S.C. 1720G, or the bill be revised accordingly if it is intended apply to a broader population of family members and caregivers.

VA is still examining the potential costs of this draft bill.

S. 1586—ENHANCED DENTAL CARE FOR VETERANS ACT OF 2013

Section 2 would authorize VA to provide additional benefits to Veterans who are eligible to receive dental services, treatment, and related appliances under section 1710(c), U.S.C., when they are needed to restore functioning in a Veteran that is lost as a result of any dental services or treatment provided under that section. VA supports section 2 in the interest of fairness to the Veteran. This is a responsibility that VA should bear, not the Veteran.

Section 3 of the bill would establish a 3-year pilot program at not fewer than 16 sites to assess the feasibility and advisability of furnishing the same dental care benefits now available to veterans with service-connected disabilities rated 100 percent disabling to enrollees who are not otherwise eligible for such services and treatment under current authorities. The pilot sites would need to include four VA medical centers with established dental clinics, four VA medical centers with current contracts for such dental care and services, four CBOCs with space available for such purposes, and four facilities selected from among federally Qualified Health Centers and Indian Health Service (IHS) Facilities with established dental clinics (of these, at least one must be an IHS facility selected in consultation with the Secretary of Health and Human Services). In selecting sites, the Secretary would be required to consider the feasibility and advisability of selecting locations in each of the following areas: rural areas, areas not in close proximity to an active duty military installation, and areas representing different geographic locations. Participation in the pilot program would be voluntary and at a Veteran’s election.

The terms of section 3 would also limit the amount of expenditures the Secretary could make for a Veteran-participant in any one-year period to the amount the Secretary determines appropriate (as determined in consultation with the Director of IHS and the Director of the Centers for Medicare and Medicaid Services if one or more FQHCs are selected as sites). The Secretary, however, could not set that amount below \$1000.

Section 3 would also permit VA to collect copayments for dental care provided to Veterans under the pilot program in accordance with current title 38 copayment authorities for VA medical care; require the Secretary to inform all eligible veterans of the services and treatment available under the pilot program; and authorize the Secretary to enter into contracts with appropriate entities for the provision of dental services and treatment under the pilot program.

VA cannot support 3. Even as a 3-year pilot program, it would represent a major expansion of services that VA could not realistically accommodate, in terms of necessary staff, capital capacity or budgetary resources. Current demands on our dental program already match, if not exceed, our current capabilities and resources. Were an entirely new group of Veterans eligible to enter the dental system, it is doubtful we could meet their dental needs (whether done through contracting or in-house). By diverting program resources to the pilot program, we would also need to decrease dental benefits available to other eligible populations, thus creating a barrier to their access to care. Of course, these concerns become even more acute should the pilot expand to become a national program without such geographic limitations.

Furthermore, should financial resources or additional appropriations be provided for this pilot program, the cost and time needed to expand the dental program would push back the start of the pilot program far beyond what seems contemplated by the bill. Operationalizing the pilot would require significant additional resources not only in terms of personnel but also in terms of needed infrastructure and durable capital costs—none of which is included in the bill. Relying instead on the private sector to provide this additional care would increase per patient costs, perhaps even greater than is currently experienced. If enacted, VHA would have no choice but to relinquish some care planning oversight to the private sector to carry out this pilot program.

Without additional resources and funding, VA’s ability to provide dental services to this new cohort of Veterans would be seriously compromised and require a shift-

ing of available resources to the detriment of others. Based on our experience, extending eligibility to this new group of Veterans would predictably result in “front loading” demand, much as we are now experiencing with Veterans who are newly eligible for dental care due to increases in their service-connected ratings. In short, the pilot sites would be quickly overwhelmed by this new cohort’s dental needs and their needs would largely go unmet. The dental benefits intended to be delivered under the pilot program would simply not be available.

In addition, the pilot program that would be established in section 3 raises equity concerns. Only enrollees fortunate to be served by a selected pilot site would be eligible for the dental benefits described in the bill, while equally deserving enrollees outside of those catchment areas/sites would still lack eligibility for needed dental care. While pilots by their nature are selective, we believe the desire for these services may be so acute that it will create stronger than usual immediate inequities, as well as expectations regarding future availability of these benefits across the country that will be difficult to fulfill.

Fortunately, another option exists by which the dental needs of these Veterans could be addressed. The Dental Insurance Pilot Program (DIPP) currently allows enrolled Veterans to buy dental insurance for use in receiving care in the private sector. This pilot is starting November 15, 2013, and enrollees who are not currently eligible for VA dental benefits could take advantage of this opportunity.

Section 4 would require VA to conduct an educational program promoting dental health for enrollees. The program would include specified information disseminated through mechanisms described in the bill. VA supports section 4 of the bill as a favorable means by which to promote dental health. In fact, VA has already initiated some of these efforts and would welcome the opportunity to do more in this area.

Section 5 would require VA not later than 180 days after the date of the Act’s enactment to expand the current DIPP to include a mechanism by which private sector dental care providers may forward to VA (for inclusion in the patient’s VA electronic medical record) information on the services they provide, when the Veteran has elected to participate in the use of this mechanism. Section 5 also authorizes VA to extend the pilot program by 2 years if needed to assess this mechanism.

Although VA would welcome an extension of the DIPP for reasons unrelated to the bill, we do not believe the requirement for DIPP contracts to include a mechanism by which to allow submission of information to VA (for inclusion in the Veteran’s individual electronic medical record) is needed. Veterans can already submit private medical records, including dental ones, into their personal electronic medical record.

Such a requirement would impose administrative disruptions and could have unintended consequences on dental care. Namely, it would alter contracts now in place, potentially requiring them to be re-competed. In addition, it could result in the direct costs associated with use of such a mechanism being passed on to Veterans, as the dental insurance carriers would likely recoup theirs and providers’ costs through billing of increased premiums. This type of requirement could also limit the providers who are willing to accept VA dental plans, thereby hampering or minimizing Veterans’ access to private dental care, thus defeating the purpose of the DIPP.

If enacted, this bill, particularly the provisions of section 3, would have very significant budgetary impact. We will provide our cost estimate to the Committee as soon as our analysis is completed.

S. 1588—REIMBURSEMENT FOR EMERGENCY MEDICAL TREATMENT

VA supports S. 1588, which would expand eligibility for reimbursement for non-VA emergency care for nonservice-connected (NSC) conditions when the enrolled Veteran seeks but does not receive VA health care in the 24-month period preceding the emergency treatment because VA was unable to provide a new patient examination in time for the Veteran to fall within the 24-month window in current law.

Currently, Veterans who are otherwise eligible for coverage under 38 U.S.C. 1725 are deemed ineligible for this reimbursement if they have not been seen at a VA health care facility within the preceding 24 months, for any reason. VA believes that Veterans should not lose eligibility for reimbursement if they seek VA care within that 24-month period but, for reasons attributable to VA, do not receive a new patient examination in time for the Veteran to satisfy the 24-month requirement. S. 1588 is consistent with this view. VA estimates this bill would result in an additional expenditure of \$21.6 million over a 10 year period.

S. 1593—SERVICEMEMBER HOUSING PROTECTION ACT OF 2013

S. 1593 would amend the Servicemembers Civil Relief Act to expand protections for servicemembers with regard to residential leases and for their survivors with regard to mortgage foreclosures. This bill has little effect on VA programs. This bill would largely affect issues relating to current members of the uniformed services and consequently is primarily of concern to the DOD, Homeland Security, Health and Human Services, and Commerce. Accordingly, we defer to those departments' views on this bill.

S. 1604—VETERANS HEALTH CARE ELIGIBILITY EXPANSION AND ENHANCEMENT ACT OF 2013 (REVISED)

Section 2 of the bill would amend 38 U.S.C. 1710(a)(3) by replacing “may, to the extent resources and facilities are available” with “shall.” If section 2 were enacted the Secretary would be required to furnish hospital care and medical services to all Veterans, albeit some Veterans (those covered by 38 U.S.C. 1710(a)(3)) would have to pay copayments for this care. As amended, subsection (a)(3) would also specify that the Secretary shall furnish necessary nursing home care to Veterans not covered by (a)(1) or (a)(2). Currently under 38 U.S.C. 1710, the Secretary’s authority to furnish nursing home care to Veterans covered by subsection (a)(2) and (a)(3) is discretionary. Mandatory nursing home care is addressed in 38 U.S.C. 1710A. As drafted, Section 2 could be read to expand the mandatory nursing home population to include veterans covered by 1710(a)(3).

VA reads 38 U.S.C. 1710 in conjunction with 38 U.S.C. 1705. While section 1710 authorizes VA to provide hospital care and medical services, section 1705 specifies how VA is to manage the system of patient enrollment. Although the language in section 2 would not impact the Secretary’s authority to manage the enrollment system, if all Veterans are considered to have mandatory eligibility the continued effect of the enrollment system is unclear. Until VA has the opportunity to further discuss the intent of the provision with the Committee, it cannot support nor provide cost estimates for section 2.

As we noted in our testimony, section 3 of the bill requires detailed consultations with other Federal agencies. VA reserves analysis of those issues for a later time, including the opportunity to discuss them with the Committee.

Section 4 of the bill would expand the combat eligibility provision in 38 U.S.C. 1710(e)(1)(D) for Veterans discharged after January 28, 2003, from 5 years from the date of the Veteran’s discharge to 10 years. Section 4 would also extend eligibility for Veterans who were discharged before January 28, 2003 until January 27, 2018. Section 4 of the bill is currently being evaluated and costs associated to this provision are under consideration. VA has had extensive conversations with the Chairman and staff, who realize the complexities of the provision. VA will provide views and costs on the measure at a later time. We look forward to continuing discussions with the Committee.

Section 5 would delete 38 U.S.C. 1710(a)(4) and add similar language to 38 U.S.C. 1707. These amendments do not appear to make substantive changes to eligibility for VA health care or VA’s enrollment system. However, if enacted, we recommend that the phrase “subject to paragraph (a)(4)” in 38 U.S.C. 1710(a)(1) and (a)(2) be amended to reference the new provisions of 38 U.S.C. 1707. In addition, we would also recommend that a similar reference be added to 38 U.S.C. 1710(a)(3), as amended by section 2 of this bill.

Section 6 of the bill would direct VA to make certain modifications for purposes of determining whether veterans qualify for treatment as low income families for enrollment under 38 U.S.C. 1705(a)(7). Specifically, the income thresholds applicable to Priority Group 7 would be modified so that one low income threshold would be applied to a State, equal to the highest “low-income” threshold among the counties within that State. The “geographic means threshold” (GMT), which is based on calculations done by the Department of Housing and Urban Development, is currently based on 80 percent of the local median income. This bill would set a statewide threshold at 80 percent of the median income in the highest earning locality in a state (at the Metropolitan Statistical Area).

Equalizing GMT thresholds across broader geographic regions would likely make the eligibility criteria easier to understand and appear more equitable among Veterans residing in close proximity within a State. However, significant differences in the GMT thresholds across state boundaries will still be possible. Also, by increasing the GMT thresholds, a significant number of current enrollees in Priority 8 will be re-classified as Priority 7 and thereby enjoy the lower inpatient copayment levels associated with Priority 7. This will result in a substantial reduction in “first party” revenue. In addition, increasing the GMT thresholds would also expand the pool of

Veterans eligible for enrollment in Priority Groups 7 and 8, many of whom are not currently enrolled. VA estimates that approximately 1.8 million Veterans would fall into the newly expanded Priority 7 income window, of which approximately 1.4 million are not yet enrolled. VA cannot support section 6 without further discussion of the effect of such an increase in enrollment would have on the care provided to currently enrolled Veterans, as well as the budget resources that would need to be made available to support such an expansion. VA estimates the cost of section 6 of the bill would be \$370 million over 5 years and \$3.3 billion over 10 years.

Section 7 of the bill would require VA to use the capitation-based resource allocation model in entering into contracts for the furnishing of health care services. This would be a substantial change to the payment structure for non-VA medical care. VA needs to retain flexibility for its payment models and therefore does not support this provision.

VA estimates that there would be no specific costs associated with this provision. However, VA typically sends care out to the community when it cannot be provided in the VA. Therefore, it is usually episodic in nature. A capitation-based payment methodology generally is more cost-efficient when used to pay for a complete treatment cycle for a diagnosis, but may not be for episodic care.

Chairman SANDERS. Thank you very much for your testimony. Let me begin with a few questions with Dr. Jesse. In your judgment, does the VA provide good quality, cost-effective health care? I know you are not objective about this.

Dr. JESSE. Well, I would say that if I did not feel that it did I would not be in the position I am in now. We know that things happen in VA. You mentioned that earlier. If you look across health care systems and compare in the objective ways that we can, VA provides excellent care in many of the areas by which we measure the effectiveness and the quality of health care in the US. So, on that basis, that objective basis, I would say yes, we do.

Chairman SANDERS. And consumer satisfaction is fairly high, is it not?

Dr. JESSE. Consumer satisfaction is fairly high. It is not as high as we would like it to be; but when you compare satisfaction with the care in the VA system to other large health care systems, in many respects they are comparable.

I think a lot of our efforts are really being driven now toward improving that consumer satisfaction. Much of the strategic issues that we are moving forward in VA health care, starting a year or so ago but moving rapidly forward now, are really focused on building a health care system that is driven by the patient and their individual needs, not by the statistics of large numbers or meeting the needs of the health care system.

Chairman SANDERS. Let me ask you this.

Dr. JESSE. Sure.

Chairman SANDERS. My impression is that there are many veterans who would like to get into the system but for a variety of reasons do not. Some of them get to the issue that we discussed a moment ago about outreach and some of them do not even know the benefits to which they are entitled.

I think VA is beginning to do a good job. We will probably have a hearing on that issue but I think we are making some progress in at least informing veterans of the benefits to which they are entitled.

But my impression is that there is a lot of confusion about eligibility levels. In Vermont, if Senator Begich were to live in one county and I live literally a mile away from him in another county,

he might be eligible; I might not be eligible. I think that makes it difficult for folks to do outreach work.

So, my impression is in Vermont, and I suspect around the country, that there are a lot more veterans who would like to access VA health care than are able to do so today.

Do you agree or not?

Dr. JESSE. I will agree at least anecdotally because I hear much of the same things that I think you are hearing. I cannot quantitate it, but I do know—and particularly of interest is people who would be in what we call category eight who are not eligible based on a means test, who are perplexed because they say I would love to get my care in the VA.

Chairman SANDERS. Exactly.

Dr. JESSE. And VA would actually bill their insurance company so we would not be costing more money. But the way we are stratified, it does not allow us to do that.

Chairman SANDERS. So, one of the areas that we are going to work on is to expand and simplify VA health care. One of the folks who works for me in Vermont gave me a telephone book. It was literally a telephone book. What do we do now? Every zip code or something. Is that the eligibility level?

Dr. JESSE. I am not sure exactly how that works. I might want to defer to the benefit side.

Chairman SANDERS. So, if I live in one zip code and Senator Begich in another, our eligibility levels are different? I believe that is the case, is it not?

Mr. MCLENACHEN. Mr. Chairman, are you asking about health care eligibility?

Chairman SANDERS. Yes.

Mr. MCLENACHEN. I would have to defer to—

Chairman SANDERS. Ms. Joyner. All right. We are going to find it. Mr. Hipolit, you are next.

Ms. JOYNER. Actually, I am not sure exactly what the criteria is. We could take that for the record and get it back to you.

Chairman SANDERS. Well, there is a telephone book, and it is pretty crazy and pretty complicated.

Ms. JOYNER. It is very complicated, yes.

Chairman SANDERS. If our goal is to simplify and bring people into the system, a telephone book which has his income level different than mine and we live two miles apart makes no sense at all to my mind. So, we are going to work on that.

I want to switch gears for a moment. I am going beyond my time here, and ask, Dr. Jesse, if you consider lack of access to dental care a serious problem in our country and for veterans?

Dr. JESSE. It is a serious issue in our country; and by that very nature, it is an issue for veterans. I am a cardiologist. It has been known for 20 years that periodontal disease has a linkage to heart attacks, for instance. It creates a systemic inflammatory state which drives a number of different issues.

So, dental health is part of a holistic approach to health as in all other forms. So, yes.

Chairman SANDERS. Right. Would I be wrong in assuming that if we said—and I understand this is an expensive proposition, and I understand that we cannot do it all tomorrow—but what would

your reaction be if we said to veterans around this country that we understand health care to include dental care? We know that many of those folks have serious dental problems and they cannot afford treatment elsewhere and that we were going to open up VA facilities to non-service-connected as well for dental care.

Do you suspect there will be a lot of people who would be interested in taking advantage of that opportunity?

Dr. JESSE. That I would not even suspect. I can tell you that there would be. I have patients, I still see patients, that are in exactly that bind that you discussed. We can provide complex heart attack care for them, but we cannot provide relatively simple dental care.

Chairman SANDERS. Ok. So, I would look forward to the cooperation of Members on the Committee on this. This is an issue, I think, that is long overdue and it needs to be addressed. My time has expired.

Senator Johanns.

Senator JOHANNNS. Thank you, Mr. Chairman, and to the panel, thank you for being here today.

Let me start out and say I have no quarrel with the Chair's assertion and your assertion, Dr. Jesse, that there is quality care at the Veterans' Administration. All of us have seen some of the most remarkable things.

I would go as far as to say that not only is it quality today, it continues to improve and in some areas it is trendsetting. Everybody looks to the VA to see how you are doing things to try to put that in practice at their health care center.

But I do have a question about facilities because in my State, we are on some kind of list relative to a veterans hospital that services Nebraska and western Iowa. I think we are 18th out of 20 on this list. I do not even know if anybody can predict when you get to the 18th but rest assured I will be a much older man before that facility gets started.

Here is the point I want to make, and I would like whoever's reaction to this. I have traveled the State of Nebraska as a Governor and now as a Senator. One of the first things that communities want to show me is their health care facility. I have been in some of the smallest communities in Nebraska, and they will take me to their hospital.

It is remarkable what they are doing with this small critical access hospital. It is a beautiful facility. It was just built within the last, you know, 5, 10, 15 years. Unbelievable. And I will go down the road 50 or 75 miles and I will see it again.

By comparison, I go to the VA hospitals, and I will just tell you I do not think they are up to standard. They are 1940–1950s style hospitals. You go in the operating room, and God bless the doctors and nurses and the health care providers, but they are working in conditions that I just think are not up to today's standards. These facilities are way out of date.

The VA is in this very difficult situation of patch, patch, patch; and it seems like wasted money. Here you have this building that really, really should not be standing anymore and we are putting millions and millions of dollars into it.

I am offering this in a global sort of way because I do not want this to sound completely about my State because I think I could find this in most any State in the country.

How do we go about solving that problem because, like I said, if we stay at 18th, you know, it is almost like giving up hope that we will ever move up in the list. Give us some advice on how we can match our health care facilities with the capability of the health care providers that are working with our veterans in those other beautiful facilities.

Dr. JESSE. Sir, I want to, if I may, take two approaches to that. One is that you are absolutely correct in that many of these facilities do not just appear old, but they are old and become difficult to maintain.

I would like to say, though, that what is at the cosmetic end of this is not necessarily what is behind the wall. So, how our ORs conform to modern standards for air flow, infection control, et cetera, part of the issue is it is very expensive to maintain them in those ways. It is very expensive in these old hospitals to run the kind of channels that you need for modern electronics, communications systems, et cetera, at these places.

The simple answer, which is not intended to sound facetious but is it takes money. In some respects, it may well take a reconfiguring of the approach we have to health care in the small communities.

I am a huge fan of the critical access hospital system. I am hugely concerned that there are at times in this country the concern that the surrogate for quality is volume and that nothing good happens in small places, and I do not think that is the case at all.

I think, amongst other things in VA, what we have shown is if we can manage quality, by managing quality we can do great things in small places. In terms of the building out, though, and how we distribute our footprint in ways that is most acceptable, again there is going to be some rethinking about what those facilities look like.

There is going to be a greater use of health care delivery systems without having to come to a hospital. So, we can use those face-to-face resources, those hands-on resources in the most optimum ways and say frankly in your State and any State that is considered rural, people do not have to travel the kinds of distances they need to.

But in terms of how we prioritize new construction, new facilities, we have a process, a fairly formal process for doing that. It is fundamentally driven around safety, patient safety.

One of the things we have learned is that you can always put somebody at the bottom of a list if that is the only thing that you drive on; and we are actually now working through processes to better bring up, you know, these other needs rather than just driving everything solely on patient safety and physical safety and on facility safety.

Senator JOHANNIS. Mr. Chairman I am out of time on this but I bet you I strike the chord with everybody. Just as a respectful suggestion it may justify a hearing to try to figure out how best to proceed because, like I said, this is not unique to Omaha, Nebraska.

Chairman SANDERS. I think you are right. It is not unique. What we have to deal with is money. It is an expensive proposition but long term it may be cost-effective rather than patching up older buildings is what you are saying.

Senator JOHANNIS. Yes.

Chairman SANDERS. Thank you very much, Senator Johannis.

Senator Hirono, would you mind if Senator Begich makes opening remarks?

Senator HIRONO. Sure.

Chairman SANDERS. Thank you very much.

**STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA**

Senator BEGICH. Thank you very much, Mr. Chairman. Thank you, Senator Hirono, for allowing me since I have to run off.

I want to follow up on Senator Johannis' comments for a second.

But to the panel here, thank you. I know there are some issues you have with a couple of bills I sponsor. One is a whole effort to create outreach for veterans especially in rural areas which is a big demand and I know there are some pieces to the equation. I would love to get your input additionally as we work through this because it is critical especially in rural Alaska.

We find veterans on a regular basis that do not have access or are totally unaware of what benefits they are owed based on their service. In rural Alaska it continues to be a problem and I know it happens in other States. So, I would like to further work with you on Senate Bill 1558.

The other one is S. 1580, which is pretty simple. This one is when we work with facilities that have—we are using a per diem payment regarding homeless veterans. As mayor I had to call the fire department more than once for inspections on facilities that are contracted with VA to, in theory, provide shelter for the homeless which sometimes fall below standards.

Now, I know you all kind of do this process now, so this bill will just codify that, make sure that is the law, that you cannot pay a per diem to a facility that is not meeting safety standards of the local community they are stationed in. I know you do that informally now but we want to make sure it is codified.

We also want to require that when you then stop making payments, this Committee and the House Committee is notified so people understand it because obviously you will get calls immediately. I can just tell you as a former mayor that is something that I noticed more than once.

So again, I wanted to note those bills and I thank you.

A third bill which we were going to discuss today but was pulled off because we have to work on some language, goes to this facilities issue in the longer term.

First, I want to commend the VA because of the work you have done with our State and now expanding that to the Indian reservations. We will never see, I would love to see a veterans' hospital in my State. But if Nebraska is number 18, we are probably number I do not know what.

So we have tried to do something a little different that the VA has worked with us in kind of like a—if I can say this word, I am

not sure it is the right word, but—a demonstration of seeing if this would work.

We have been in health care service facilities, beautiful facilities. As a matter of fact, I just visited one in Fairbanks that had 22 dental health stations, and I mean top-quality dental health stations.

So, what we have been able to do with 26 of our tribes by working with the VA—now if you live, for example, in Nome, AL, again there's a beautiful, brand-new hospital built by the Indian health services serving multiple tribes. It is non-accessible by road from any major urban area but in that region several thousand people are living. 800 are veterans.

Now that veteran has a choice. They can walk into that facility, get service, VA will reimburse them, or fly to Anchorage or Seattle where the VA clinic and the VA hospital is located but they still get a choice.

The best news is, it is not only Indian health services for native veterans. It is also for non-native veterans, this new experiment which so far from what I am hearing has been working. You have a line item in your budget now to allocate resources to this. It is also now being considered for expansion to Indian reservations, which is a very complex situation.

So, you have an Indian health service facility right there but in order to go to the VA facility you have to pile into a van, go drive out to it, wait for everyone to get their services, then get back in the van and drive back out.

I think there are some innovative approaches here in one of the bills that we drafted—we are tweaking some language on it—which will create this opportunity. For example, we have another beautiful hospital finished by Indian Health Services in partnership with our tribal consortium, and the top floor is empty.

But the VA clinic down the street is packed beyond capacity. So the thought is to let us put them together, because as long as quality care is there—and that is the key here—I think we can leverage our assets much differently.

I want to thank the VA for being willing to take on this experiment. I know there is a little concern not just by you but by other national organizations because they were concerned about the privatization of VA, and they were concerned about the quality of care because there is inconsistent care within the Indian health services just like the VA. Even though we are trying to get to a high standard, there is inconsistent care.

The program we have in Alaska for Indian health care service is such a model. Internationally, folks look at it. They fly from around the world to come to see our Indian health care service delivery system. I know you guys have gone to it to borrow some of our telemedicine.

Dr. JESSE. South Central.

Senator BEGICH. Yes, the South Central clinic.

So, I just wanted to put that out there because I think at this point, and it is actually an interesting idea because it does beg the question of how we maximize—when the capital improvements list is so long on such limited resources. So, we have these other resources happening that kind of work in their own silo.

Chairman SANDERS. Let me just jump in. I am sorry.

Senator Hirono, we are going to get to you in a second. I appreciate your patience. [Laughter.]

Senator BEGICH. I know she cares about this issue too.

Chairman SANDERS. Right. She is in a very rural State as well.

Two questions, Senator Begich, number 1, if a veteran walks into an Indian health service dental facility, will the VA pay for that dental care?

Senator BEGICH. That is a great question. I do not know. It depends I think on the care and the need and what they are qualified for.

But the greatest thing I have to tell you, Mr. Chairman, is the one in Fairbanks that just opened, the Tanana Chiefs facility, well, I wish when I was growing up as a kid in Alaska I had that kind of dental service. I mean, it is unbelievable care. But what they provide you with is unique and why the VA—we have to equalize these systems.

Chairman SANDERS. The other point that I would make is one of the things that we are looking at—Senator Johanns, you would be interested in this as well—is we have many, many hundreds, in addition to Indian health service clinics, we have federally-qualified community health centers.

Senator BEGICH. Yes.

Chairman SANDERS. And the same principle exists. I am a veteran and there is an FQHC across the street but there is a CBOC 50 miles away. Should I be able to go into the FQHC?

Senator BEGICH. Right.

Chairman SANDERS. In talking to these service organizations, I think there is a lot of support for that concept. Some of the details have to be worked out, but I did want to let you know we are working on that.

Senator BEGICH. Let me just end this by saying first, what is unique about that system—at least the Newcomb model as we call it in the Indian health services in Alaska and the new emerging community health care systems—it is the newer model of delivery systems.

So, when you walk in, how is your hearing, how is your eyesight, how are your teeth—

Chairman SANDERS. Holistic.

Senator BEGICH. Very holistic. And why is that important? Because it cuts the cost of emergency care. I will give you one last note: the native hospital in Alaska has cut their emergency care recipients going in by 68 percent.

Chairman SANDERS. That is an enormously important point. We spend billions of dollars because people do not have access to primary health care and they end up in the emergency room at 10 times the cost.

Senator Hirono, because you have been so patient you are going to get extra time.

Senator HIRONO. Well, thank you very much. I do not think I will need 10 minutes but be that as it may.

Dr. Jesse, in your testimony I do not think that you gave us your position or the VA's position on my bill relating to the 24-month Catch-22 situation that new veterans face. So, I hope that you will

be supportive of this kind of a change because they are in a situation over which we have no control.

Dr. JESSE. I am glad you spoke to it the way you did because I do not think going in I fully understood that Catch-22 piece that was in there. You know, I clearly was looking at the issue of access to emergency care in general but that is a real important point you bring up and we will bring that back.

Senator HIRONO. The other thing is that Mr. Atizado of the Disabled American Veterans, he will be in the second panel, but he noted that while my bill addresses the new veteran, there is still this 24-month requirement for all other veterans.

So, within a 24-month period, a veteran has to go and get some kind of treatment at a veteran's facility. Otherwise, they will not get reimbursed for emergency care.

So, my question is, what steps does the VA take to make sure that veterans are aware of this 24-month requirement; and second, are you aware of anything that prevents a veteran who is already in the system, not a new veteran, from being able to visit a VA facility within that 24-month period so that he or she will be covered?

Dr. JESSE. So, there are a couple of things here that address this. One is I do not think there is anything in the way of anybody coming to a VA facility and getting literally enrolled on the spot if that is the case and hence get coverage.

It has been really since the post-9/11 ramping up, the very clear direction from the Secretary that if somebody comes into a VA facility and says that they are a veteran, they should get care and we will figure out eligibility status later. I think that is an important statement.

Then, the other piece of that is in part outreach, but this was a component of the Secretary's transformation, T-21 transformation issue. But there is literally a handbook that can be, it is being personalized to each veteran that we mail to or they can actually get electronically. I think you can pull it down now off of, the general version, not the personalized version, off of Amazon or one of the booksellers.

But the notion as this was being developed is that when we know the veterans, who they are, we can reach out to them and say you are eligible for this care based on your service. This is your nearest VA or your nearest clinic. This is who to call to ask questions.

Senator HIRONO. Well, apparently there is this 24-month requirement; and if they miss that timeframe, they cannot be reimbursed. So, my question is, are they reminded that you need to have gone to a veterans' facility otherwise you are going to lose this reimbursement benefit?

Dr. JESSE. That I do not know.

Senator HIRONO. So, I think it has come up a number of times, the lack of information and the need to provide information, not just once because I am sure veterans get tons of stuff that they are supposed to remember but, you know, who can.

So, if they are going to be disallowed certain benefits because of a timeframe, then we should figure out how they can be timely reminded.

Dr. JESSE. We are actually terribly concerned about this in particular with the Guard and the Reserve who are not connected through the DOD directly. We do now have a discharge process, getting out of the military and going back into their community, that literally takes a couple of days and all of these issues are gone through with them. Then we reach back out to veterans usually within 6 months to 1 year of there being separated, again about their qualifications for VA.

So, it sounds like we might need to do a little bit of a job there.

Senator HIRONO. Yes, I think you get our concerns. It cannot just be at the time of their discharge because these things, they need to get timely reminders. It is like getting your teeth cleaned every 6 months or so and you get your notice.

I wanted to go to the Chairman's bill, S. 1581 which would authorize treatment at VA facilities, not at regular non-VA facilities, for military sexual assault victims; and these are people who still are on active duty. My understanding is that the VA system may have a process or they have counselors and others who may not be in the regular systems.

So, would you support this kind of a change or this kind of opportunity?

Dr. JESSE. In principle, the answer to that is absolutely yes because we do it through the Vet Centers. So, there are 300 Vet Centers, 70 mobile; and they are authorized for active duty people to use.

Authorization for active duty to use VA facilities for certain things, I do not know if that creates a different set of problems; but we are very attentive to the issue of military sexual trauma. It is part of the screening process for every clinic visit.

We screen for alcoholism. We screen for suicide. We screen for military sexual trauma. So, it is an issue that is important to us, that we are very much attuned to, and I just do not know with enough certainty to say that if a military person walked in, what the implication of treating for one limited condition would be. But in the Vet Centers we do.

Senator HIRONO. OK. I think the Chairman's bill is a good bill and that these victims may, in fact, prefer to go to VA where maybe they feel that there is more privacy, et cetera. So, I think we should figure out a way that we can have this happen and then whatever coordination of their records, et cetera, that needs to occur should be something that we should pursue.

Dr. JESSE. As I said, we did realize this as being an important issue and the authority within the Vet Center system, again which has a very broad footprint across the country, is able to do.

Senator HIRONO. OK. We shall continue.

Chairman SANDERS. Thank you very much, Senator Hirono.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you again, Mr. Chairman, for holding this hearing and thank you to each of the witnesses who are here today for service to our veterans.

Let me begin, Dr. Jesse, and you can ask one of your colleagues to answer, if necessary. As you know, I have focused on the electronic records challenges and, in fact, have sponsored the Servicemembers Electronic Health Records Act, along with Senator Nelson

to address what I see as the unfortunate and unforgivable lag in the development of a truly seamless, interoperable system with the Department of Defense.

Essentially, all this act really does is establish some deadlines. Do you have a position on the bill? I hope that you will support it.

Dr. JESSE. Sir, I do not think we have a formal agency position. Every one of the points you bring up are important and are a part of the complexity of working both in health IT space, which by itself is a challenge, and also doing this across Federal agencies.

You use the term interoperable. I think that data interoperability is hugely important and I think is achievable. Integrated so that everybody is using the same record creates a different set of challenges but is probably, you know, built on the foundation of data interoperability, data visibility, data viewing is the first foundational step that needs to occur. I think that is probably on a lot more solid grounds.

In terms of timelines, you know, to say a very general statement, when you have timelines, things tend to happen toward those timelines. When you do not, they tend to lag. They tend, you know, to drift.

Senator BLUMENTHAL. Well, I do not mean to make you the target of my unhappiness—

Dr. JESSE. Thank you. Yes.

Senator BLUMENTHAL [continuing]. Because I recognize that this issue goes well beyond your job description or jurisdiction.

But the answer that you have just given, "that it is achievable" is the same answer that I have been given literally since I arrived here which was 2-½ years ago. I cannot accept that at this point in time the goal is achievable but not achieved, and so I am asking you to commit on behalf of your agency. I hope you will take this question back to General Shinseki, either to commit that you will meet the deadlines in the bill or to offer full support for the bill because if we need to compel you to do it, in my view, we should do so giving you the resources you need and giving the Department of Defense the mandate that it apparently needs so that these goals are not achievable but are it, in fact, achieved according to this timeline which I think is realistic.

You know, I will just say to you, and I do not mean to be condemnatory, but when people raise the issues of the Affordable Care Act and some of the IT issues that have been confronted there and say to me I have never seen this kind of mess before. Well, the difficulty of making the DOD and VA electronic records systems interoperable strikes me as very much of the same ilk, very distinguishable. I recognized technically maybe wholly unlike but in the view of laymen or nonexperts like myself, the same question is why can we not get it right.

Dr. JESSE. I appreciate the support, and we will take that back in terms of our formal views; and if there is anything we can do to provide you more information, we are happy to do that.

Senator BLUMENTHAL. I recognize also that it is not wholly within your power. There is a potential partner here that has to be incentivized or maybe compelled under law, the Department of Defense, to do the right thing here. I know that there is a history. So, I say all of the above with all due respect.

Let me ask you a final question. I know that you have seen countless individuals like Justin Eldridge whom I have described earlier who took his own life after a struggle with Post Traumatic Stress.

I did not recount today but I did in my remarks this morning on the floor that he actually knew he had a problem and was told he had to wait before he could be given treatment. That was some time ago.

His history is more complicated but the question is, are we doing enough? Are we providing the care as rapidly as we need to do?

I should have prefaced my statement by seconding the remarks of some of my colleagues.

The VA hospitals do remarkable work. They help people in extraordinary ways. I am a great admirer of what the VA has done on issues of health care delivery to lead the way for our Nation. So, this is not a hostile question. It is, again, more a supportive one.

Dr. JESSE. So, first of all, any suicide is absolutely tragic, and we do not just try to count numbers. We really try to understand. People do not commit suicide because they want to die. They commit suicide because they want the suffering to stop. Often, we do not see where that suffering really lies.

Much of what we are doing toward that end now—we are very good in the rescue of the potential suicide people who call the crisis hotline. That organization does amazing things.

We need to be working much further back in the stream. How are people suffering? You know, is it pain, is it PTSD, is it other things? And get those resolved as quickly as possible because that is how we support people.

Thank you.

Senator BLUMENTHAL. Thank you. My time has expired but I thank you very much.

Chairman SANDERS. Senator Burr.

Senator BURR. Dr. Jesse, as it relates to the Alicia Dawn Koehl Respect for National Cemeteries Act, understanding that this is a unique case, what steps has VA taken to ensure that this does not occur again.

Dr. JESSE. May I defer that?

Senator BURR. Sure.

Mr. MCLENACHEN. Senator Burr, the VA does support the bill. You know, it is unfortunate. You heard some testimony about how long it took to resolve that issue. It was a complex legal issue and I will defer to Mr. Hipolit about those.

But this is a very rare occurrence but the conclusion, the legal conclusion that the General Counsel's Office reached was that legislation was necessary to solve this problem in the cases where it does arise.

Senator BURR. Let me ask you in reference to the future. Would a question on the burial application asking whether the veteran who is to be buried committed a capital crime or other disqualifying offense be effective?

Mr. MCLENACHEN. Well, it is my understanding—and again Mr. Hipolit can correct me if I am wrong—but it is my understanding those questions are asked currently when someone appears to sub-

mit an application. In fact, the information we have from the National Cemetery Administration is that there were 107 yes answers to that question during the last fiscal year.

Mr. HIPOLIT. I can amplify on that a little bit. Yes, there is a question there. They do ask whether the veteran committed a capital crime. A lot of times these things are taken in over the phone or the funeral director or through the National Cemetery Administration scheduling office. In many cases, the funeral director may not know the information.

Senator BURR. So, the answer is obvious if they are transferred from prison; but if they are not transferred from prison, then that is sort of a potluck as to how it gets answered?

Mr. HIPOLIT. Well, they do have that question. They do try to find out the information. If there is any indication based on the response that there may be an issue, like if they say they do not know or whatever, then they do provide further follow-up.

Senator BURR. Well, it is crucial that we get this bill passed, and I think my colleagues understand that.

Dr. Jesse, I want to talk about the efforts for the VA National Dialysis Center Program. I understand the VA is opposed to my legislation because it would delay until mid-2015 the national roll out.

Now, why did VA decide to move forward with this expansion in direct opposition to Congressional direction which you would find in last year's MILCON/VA approps bill?

Dr. JESSE. So, I am a bit at a loss because I am not aware that it is moving forward. We have got four pilots. I think—

Senator BURR. Well, let me stop you if I can because there was in *Sources Sought* a notice released on October 9, 2013, on FedBizOpps.com for National Dialysis Equipment Request by VA, which, as I understand from my staff, the notice states, "The objective of this effort is to provide standardized Hemodialysis Systems (also referred to as Dialysis Machines) and associated Hemodialysis System Maintenance to facilitate the stand-up of VA Dialysis Centers throughout the Nation." In September, VA agreed to put the expansion on hold until January after we tried to attach the dialysis bill.

But all of a sudden there is a solicitation out there with a note that the VA intends to stand-up dialysis centers throughout the Nation.

Dr. JESSE. So, I think the nuance here is a freestanding dialysis center versus dialysis capabilities at VA facilities. Now, I am not aware that the—

Senator BURR. Well, I am reading from what it said in the note, "* * * VA Dialysis Centers throughout the Nation."

Dr. JESSE. Well, we provide dialysis throughout the Nation. As I am saying, I am not aware of this. I will take that for the record. But I am not aware that we have made any solicitation to further expand free-standing dialysis centers. Now, we are, as you know, trying to standardize—

Senator BURR. Well, there was an effort, there was an effort to start to roll out the national VA system, right?

Dr. JESSE. Well, I think we agreed that we would do this pilot.

Senator BURR. Well, let me ask you. What is the purpose of a pilot?

Dr. JESSE. The purpose of this pilot is to understand: (A) does it provide the level of access that we need; and I think the largest issue in dialysis moving into the future is capacity.

Senator BURR. Does the VA have a metrics that they look at?

Dr. JESSE. (B), is it cost effective.

Senator BURR. And have all the metrics been put together?

Dr. JESSE. Well, many of the metrics have been put together. The initial location of the pilots was—

Senator BURR. Cleveland has only been open 3-½ months. What could you learn or glean from Cleveland?

Dr. JESSE. At this point, what we can glean from Cleveland is the complexities and costs of standing up the facility which we have done for all the others. Cleveland was late in getting up because of contracting issues, frankly.

Senator BURR. Have you learned enough from the 3-½ that have stood up that this is a smart move, to nationally do for the VA?

Dr. JESSE. Well, I do not think we have concluded that analysis. I would defer the answer until we actually have. I mean, it is appearing cost-effective. That may be a moving target. The more the dialysis becomes—without meaning this in a pejorative sense—becomes commoditized, and by that I mean we have now dialysis centers that sit in strip malls—not VA, but in this country—rather than being attached to health care facilities or hospitals.

The real issue is people who need dialysis need it on a frequent basis. The whole system may change if, in the next year or 2 or 5 or 10, somebody comes up with a system to do home dialysis in a much easier way.

Senator BURR. Would you be kind enough to share with the Committee the metrics that were used to make a determination or that you will make a determination to set up a national structure of dialysis centers that are VA facilities?

And my last question would be this, did you not just this past May sign a national plan for dialysis with the private sector?

Dr. JESSE. We did I believe, yes. I did not personally but, yes, we do have national contracts. There has been some contention around the national contracts related to what VA was paying versus relative to what CMS was paying, Medicare was paying.

You know, our goal, our responsibility is to ensure that veterans who need dialysis have access to the dialysis services that they need but we do that for many different mechanisms.

Senator BURR. In fact, you signed a plan that you said will only pay Medicare reimbursements. If the private sector chose not to agree to that, which there is some question as to whether that is—

Dr. JESSE. We are actually paying more than Medicare in some areas, I think.

Senator BURR. In some areas. But were that not to be the case, if they did not sign the contract, where would the dialysis services be provided for veterans?

Dr. JESSE. Well, this is the challenge. Right?

Senator BURR. So, that plays a part in why the VA would like to own their own infrastructure to do this; is so that there is no competitive need in the marketplace, would you agree?

Dr. JESSE. Well, so I am not sure I understand the question. The VA probably does not drive the private sector.

Senator BURR. Well, you made the comment that one of the things was that the original contract paid a price that was higher than Medicare, and that was something that in the negotiations was expressed to all private sector bidders.

Dr. JESSE. Uh-huh.

Senator BURR. And it strikes me as a little bit disingenuous that there would be pilot programs, an effort to set up a national structure that I am convinced, and I think many Members of the Committee are that would not have stopped had we not raise an issue.

All I am asking for is not to make the decision. I am asking to look at the metrics which I have been unable to access that make the cost and benefit analysis for VA doing this in-house versus VA continuing to contract with private services deliveries.

Dr. JESSE. Right. So, two things. First of all, absolutely I think that is what we owe you and I think we have said that we will do that before we move forward with a firm decision on how we would roll this out.

I think the second issue is that the VA will never be able to do all of its own dialysis in the current construct of what dialysis entails. Our responsibility is to ensure that veterans who need it can get it and particularly close to home. It makes no sense for somebody to have to drive 3 hours to get dialysis, and we would never have the capacity to do that.

When we originally looked at these pilots we looked at where do we have areas where there were significant populations of veterans who have renal failure, who get dialysis, in a range that it would make sense based on the known capacity of a dialysis unit to function effectively in these areas. They were set up as pilots, again, to understand what it would take for us to do this.

Senator BURR. The Chairman has been very kind.

Let me just say that I am not necessarily sold on the fact that the VA can produce the benefit, can deliver the service cheaper than the private sector has been able to deliver it but I look forward to you helping me with that.

Dr. JESSE. Absolutely.

[The requested information was received and is being held in Committee files.]

Chairman SANDERS. OK. With that, let me thank the panel very, very much for your excellent testimony.

Now, we have our second panel and we apologize to them for running a little bit late.

Before I introduce our panelists, I would just like to mention that Senator Burr and I are in agreement that we should discharge in the Committee from further consideration the Bill Young naming bill and hot line this bill this evening.

Anybody object to that?

If not, that is how we will proceed.

OK. I am delighted to welcome our next panel. We have Adrian Atizado, who is the Assistant National Legislative Director of the

DAV. We have Colonel Bob Norton, who is the Deputy Director of Government Relations for the Military Officers Association of America. We have also with us Rick Weidman, Executive Director for Policy and Government Affairs for the Vietnam Veterans of America. We thank all three of you very much for being here.

Mr. Atizado, we would like to begin with you.

**STATEMENT OF ADRIAN ATIZADO, ASSISTANT NATIONAL
LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS**

Mr. ATIZADO. Mr. Chairman, Ranking Member, and Member of the Committee, on behalf of the Disabled American Veterans, I am pleased to be here today to present our views on the bills under consideration. For the sake of brevity I will only highlight two bills out of those that are on today's agenda and refer the Committee to our written testimony on our views for the remaining bills.

The first bill is S. 1578. It is the Medical Foster Medical Home Act of 2013. This bill will authorize VA to cover the costs associated with the care of veterans at VA approved medical foster homes.

So as this Committee is aware, the medical foster home may be an appropriate setting for veterans who would otherwise be placed in a nursing home care because they lacked a support network to remain in their own homes.

DAV is please with VA's innovation of offering this program as part of its long-term services and support. But while patient participation in the program is voluntary, it does yield very high satisfaction among veteran residents.

In addition because of its low cost, many VA facilities perceive this program as a cost-effective alternative to nursing home placement and it is gaining popularity based on the expansion of this program over the last few years.

Because this program requires veterans in medical foster home programs to pay for their care which ranges from about \$50 to \$150 a day, even veterans who are otherwise entitled to nursing home care fully paid for or provided by VA must pay their share of residence in a medical foster home. Thus, service-connected veterans who do not have the resources to pay for their portion are unable to avail themselves of this very important benefit.

So, based on our resolution that supports legislation to expand a comprehensive program of long-term services and supports for service-connected veterans, we are, in fact, very pleased to support the intent of this bill.

We would like, however, to bring the Committee's attention to the current statutory authority which limits the VA from meeting its obligation to provide home and community-based long-term services and supports to service-connected disabled veterans such as this medical foster home program that we are discussing today.

Because of this limitation in current statutory authority, we believe the intent of this legislation should actually be codified or amend current statutory authority.

The second bill is S. 1584, which would allow qualified disabled veterans the opportunity to utilize the automobile grant program up to three times rather than the current allowance of once and increase the current amount from \$18,900 to \$30,000.

Not only has the issue of increasing the amount of automobile grant benefits has been a long-standing issue for DAV other veterans service organizations have also sought to have the amount of this vital benefit increased.

Collectively, we have urged Congress to extend the automobile grant benefit by allowing previous recipients of a much lesser amount—in years past it ranged from anywhere from 11 to 8000, even less—for those veterans to be able to receive a supplemental auto grant for the difference between their original grant and the current grant, if it was higher.

Last year, the Department of Transportation reported the average life span of a vehicle, general vehicle, was 12 years or just under 129,000 miles.

The cost of replacing a modified vehicle can range anywhere from \$40- to \$65,000 for a new vehicle and \$21- to \$35,000 used. This is on average. Now, these tremendous costs, compounded by inflation, present a financial hardship for many severely disabled veterans who need to replace their primary mode of transportation once it exceeds its expected life.

As such, in accordance with our resolution, we support an enactment of this bill as it will expand the vital automobile grant benefits by allowing multiple uses while increasing the current amount, I should say the aggregate amount, to \$30,000.

Mr. Chairman, this concludes my testimony. As always, the DAV looks forward to working with the Committee as well as the bills of sponsors' staff on any concerns that we have on their bills. I would be happy to answer any questions you or other Committee Members may have.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN M. ATIZADO, ASSISTANT NATIONAL
LEGISLATIVE DIRECTOR, DAV

Chairman Sanders, Ranking Member Burr and Members of the Committee: Thank you for inviting the DAV (Disabled American Veterans) to testify at this legislative hearing of the Senate Veterans' Affairs Committee. As you know, DAV is a non-profit veterans service organization comprised of 1.2 million wartime service-disabled veterans dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to be here today to present our views on the bills under consideration by the Committee.

S. 875, THE DEPARTMENT OF VETERANS AFFAIRS DISEASE REPORTING AND
OVERSIGHT ACT,

AND

DRAFT BILL, TO REQUIRE THE SECRETARY OF VETERANS AFFAIRS TO ENSURE THE DEPARTMENT OF VETERANS AFFAIRS HAS AN UP-TO DATE POLICY ON REPORTING OF CASES OF INFECTIOUS DISEASES, TO REQUIRE AN INDEPENDENT ASSESSMENT OF THE ORGANIZATIONAL STRUCTURE OF THE VETERANS INTEGRATED SERVICE NETWORKS AND DEPARTMENT MEDICAL CENTERS.

These measures seek to strengthen Department of Veterans Affairs (VA) policy in reporting nationally notifiable diseases published by the Council of State and Territorial Epidemiologists and the Centers for Disease Control and Prevention (CDC), or those infectious diseases required by a provision of law of a state.

Timely disease surveillance, identifying disease outbreaks, and recognizing disease trends in a community is critical to preventing infectious disease morbidity and mortality. Incomplete reporting, lack of consistent national standards, and a lack of timely reporting have created significant barriers to appropriate and effective disease-specific control measures since delays between the onset of illness and receipt

of disease notification can allow for additional transmission to occur and additional people to become ill, thereby facilitating further spread of infection.

DAV believes the intent of these bills is laudable; lacking a national standard however, we urge the Committee ensure VA, CDC and Council of State and Territorial Epidemiologists work collaboratively to ensure the resulting VA policy address any barriers or ambiguities for timely and effective disease surveillance without placing undue burden on the Department and local VA facilities. Further, consideration of these measures and subsequent VA policy should be balanced with the requirements of sections 5701 and 7332 of title 38, United States Code, that protects the confidentiality of veterans health and personally identifiable information.

S. 1148, THE VETERANS BENEFITS CLAIMS FASTER FILING ACT

S. 1148 would direct the Secretary of Veterans Affairs to provide notice of average times for processing claims and percentage of claims approved. The goal of the legislation is to encourage veterans to seek the assistance of veterans service organizations (VSOs) and file claims for VA benefits using the Fully Developed Claim (FDC) process.

This legislation would make available to all current and potential veteran claimants information regarding the success or allowance rate of claims in each Department of Veterans Affairs (VA) Regional Office (RO) by requiring the Secretary of Veterans Affairs to publish this information on VA's Web site. Additionally, this information will be required to be conspicuously posted in every VARO and, when a claim is received, VA will notify the claimant of such information, including information about the benefit of filing a FDC, such as faster processing time and eligibility to receive up to an extra year of benefit payments.

The type of information this legislation is seeking to publicize to every claimant is the average processing time of claims and the percentage of allowed or granted claims for those with representation versus those without representation. Additionally, S. 1148 will require the information to be broken down into the percentage of claims that were FDC submitted electronically versus paper as compared to those who do not file their claims through the FDC program in electronic, standard paper or non-standard paper form.

DAV supports the principle of S. 1148, which is to bring better awareness and information to a claimant prior to filing a claim for benefits in the same manner as its companion bill, H.R. 1809, which was passed by the House. Both S. 1148 and H.R. 1809 are directed at providing more in-depth information to a claimant about representation in keeping with the primary goal of encouraging claimants to submit their claims for benefits through the FDC program.

DAV agrees with encouraging claimants to submit their claims through the FDC process, as is a standard practice for DAV. Nonetheless, DAV believes, in order to fully reach the goal of this legislation and, more importantly, to benefit the claimant in the best way possible, the posted information should provide a breakdown of the number of claims represented and the allowance rate for each VSO and for representatives other than VSOs. Otherwise, this information may not allow an individual to make an informed decision about representation. Moreover, when publishing this type of information, it should include the fact that DAV and other VSOs provide representation to virtually any claimant in the process, with the exception of frivolous or fraudulent claims. Conversely, others providing representation, including attorneys, tend to be much more selective in their representation; often choosing to represent only claims wherein the predicted outcome is favorable to the claimant. DAV believes this should also be made clear to a claimant in the published information.

While we do not have a specific resolution to support this matter, DAV does support the intent of S. 1148, which will require VA to make this information available to claimants; however, we are concerned about the possibility that this legislation, if enacted, may burden the VA at a time when their primary focus is directed at reducing the backlog of disability claims and transforming the claims process.

S. 1155, THE RURAL VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT

S. 1155, if enacted, would achieve four basic purposes. First, it would amend current law governing advance appropriations in VA health care by adding appropriations accounts and sub-accounts that provide funding for information technology (IT). Second, it would add two professional fields (marriage and family therapists, and mental health counselors) to existing career health fields that are participating in VA's academic health education programs, and would require the VA Secretary to apportion funding, from funds available, to these new professions. Third, the bill would require amendments to current authority for readjustment counseling and

mental health counseling for family members of certain veterans; and, fourth, the bill would require VA to submit a report to Congress on telemedicine.

Based on DAV Resolution No. 180, DAV strongly supports Congress extending advance appropriations to all VA discretionary appropriations accounts. We believe the VA health care system's experience over the past three years, and particularly this year, protected by advance appropriations while most of the remainder of the Federal Government was forced to deal with continuing appropriations (and now a shut-down), produces a strong justification for protecting all of VA's discretionary accounts. While we support the provision in this bill that would bring IT accounts under the protection of advance appropriation, we ask the Committee rather to consider enacting S. 932, the Putting Veterans Funding First Act of 2013.

DAV has not received a specific resolution from our membership addressing the need to add the two new career fields of marriage and family therapists and mental health counselors to VA's academic responsibilities. VA already possesses authority to employ such providers, either in direct health care or in Readjustment Counseling Vet Centers. Absent a showing of shortage of available practitioners in these professions, mandating their inclusion within VA's responsibility in conducting its health care training programs may be ill advised. We defer to VA on balancing its academic programs across health professionals career fields and suggest the same to the bill's sponsor.

On the strength of resolutions from our membership we strongly support the existing VA family caregiver support program and VA's independent Vet Center readjustment counseling program; therefore, we support these provisions in this bill that would clarify and expand these efforts.

We have no objection to the report on telemedicine that the bill would require.

S. 1165, THE ACCESS TO APPROPRIATE IMMUNIZATIONS FOR VETERANS ACT OF 2013

This measure would require the Secretary of Veterans Affairs to make available periodic immunizations against certain infectious diseases as adjudged necessary by the Secretary of Health and Human Services through the recommended adult immunization schedule established by the Advisory Committee on Immunization Practices. The bill would include such immunizations within the authorized preventative health services available for VA-enrolled veterans. The bill would establish publicly reported performance and quality measures consistent with the required program of immunizations authorized by the bill. The bill would require annual reports to Congress by the Secretary confirming the existence, compliance and performance of the immunization program authorized by the bill.

DAV Resolution No. 036 calls on VA to maintain a comprehensive, high-quality, and fully funded health care system for the Nation's sick and disabled veterans, specifically including preventative health services. Preventative health services are an important component of the maintenance of general health, especially in elderly and disabled populations with compromised immune systems. If carried out sufficiently, the intent of this bill could also contribute to significant cost avoidance in health care by reducing the spread of infectious diseases and obviating the need for health interventions in acute illnesses of those without such immunizations.

While DAV is pleased to support this bill, we urge the Committee to work with VA to address concerns the Department has raised with similar legislation. Those concerns included requiring that the quality metric, including targets for compliance, be established via notice and comment rulemaking would limit VA's ability to respond quickly to new research or medical findings regarding a vaccine. Moreover, because the clinical indications and population size for vaccines vary by vaccine, blanket monitoring of performance of all vaccines could be cost prohibitive and may not have a substantial positive clinical impact at the patient level.

S. 1211, TO PROHIBIT THE USE OF THE PHRASES GI BILL AND POST-9/11 GI BILL TO GIVE A FALSE IMPRESSION OF APPROVAL OR ENDORSEMENT BY THE VA

S. 1211 would amend title 38, United States Code, to prohibit the use of the phrases GI Bill and Post-9/11 GI Bill to give a false impression of approval or endorsement by the VA.

DAV does not have a resolution on this issue and takes no official position.

S. 1216, THE IMPROVING JOB OPPORTUNITIES FOR VETERANS ACT OF 2013

S. 1216 would improve and increase the availability of on-job training and apprenticeship programs carried out by the Secretary of Veterans Affairs.

In accordance with DAV Resolution No. 001, DAV supports this legislation.

S. 1262, THE VETERANS CONSERVATION CORPS ACT OF 2013

S. 1262 would require the Secretary of Veterans Affairs to establish a veterans conservation corps.

DAV does not have a resolution on this issue and takes no official position on this legislation.

S. 1281, THE VETERANS AND SERVICEMEMBERS EMPLOYMENT RIGHTS AND HOUSING ACT OF 2013

S. 1281 would prohibit employment practices that discriminate based on an individual's military service and amends the Fair Housing Act and the Civil Rights Act of 1968 to prohibit housing discrimination against members of the uniformed services.

DAV does not have a resolution on this issue and takes no official position on this bill.

S. 1295, TO REQUIRE THE SECRETARY OF VETERANS AFFAIRS TO PROVIDE VETERANS WITH NOTICE, WHEN VETERANS ELECTRONICALLY FILE CLAIMS FOR BENEFITS UNDER LAWS ADMINISTERED BY THE SECRETARY, THAT RELEVANT SERVICES MAY BE AVAILABLE FROM VETERANS SERVICE ORGANIZATIONS

S. 1295 would amend title 38, United States Code, to require the Secretary of Veterans Affairs to provide veterans with notice, when veterans electronically file claims for benefits under laws administered by the Secretary, that relevant services may be available from veterans service organizations.

While DAV does not have a specific resolution on this issue we support the intent of the legislation to make claimants fully aware of the vast, free services and assistance that are available from veterans service organizations. Navigating the VA system and the plethora of benefits available can be very complicated and paralyzing to any claimant and we appreciate the goal of S. 1295 to help ease this burden.

S. 1296, THE SERVICEMEMBER'S ELECTRONIC HEALTH RECORDS ACT OF 2013

This measure would amend Section 1635 "Wounded Warrior" and veterans provisions in the fiscal year 2008 National Defense Authorization Act (NDAA), to create a specific timeline and deadlines for a joint electronic health record to be implemented. This timeline would require, among other things, the Department of Defense (DOD) and VA to agree on and create standardized forms for data capture within 180 days of enactment. They would have one year to attain seamless integration and sharing of information and data downloading using the Blue Button Initiative.

The bill also would require the agencies to consider storage of patient data in a secure, remote, network-accessible computer storage system or a cloud storage system. This type of storage system would allow servicemembers and veterans to upload their own information and allow their providers to have the ability to see the records at any time. The cloud storage system would increase interoperability and allow the patient to more easily share their information with their medical provider.

The development of an integrated DOD/VA electronic health record (EHR) has been beset with problems for years. Efforts to create a joint DOD/VA EHR scheduled to become operational in 2017 came to a halt in February 2013. The new plan includes both Departments to pursue separate systems and gain interoperability using existing commercial software.

The plan also assumes that in the summer of 2013, both Departments were to have launched pilot programs on the common interface at seven joint rehabilitation centers nationwide, initially, and eventually to nine sites, overall. All of the facilities were scheduled to exchange data that is computable and interoperable by the end of July.

Criticism of this decision resulted in an amendment to the House passed 2014 NDAA to increase oversight of the integrated electronic health record (iEHR). Notably, Section 734 of the National Defense Authorization Act of 2014 would require DOD and VA to give appropriate congressional committees a plan on an iEHR by January 31, 2014. This plan would include program objectives, organization, responsibilities of the departments, technical system requirements, milestones (including a schedule for industry competitions), system standards the program will use, metrics to assess the program's effectiveness, and funding levels needed for fiscal years 2014 to 2017 in order to execute the plan. It would also limit funding for development of an iEHR until the Government Accountability Office confirms the proposed system to be deployed by October 1, 2016, meets stated requirements.

We note that despite strong and consistent Congressional mandates and oversight over those years, efforts by both Departments remain fragmented and have proceeded at a glacial pace. As part of *The Independent Budget*, DAV remains firm that the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and that allows for two-way, real-time electronic exchange of health information and occupational and environmental exposure data for transitioning veterans. Effective record exchange could increase health care sharing between agencies and providers, laboratories, pharmacies, and patients; help patients transition between health care settings; reduce duplicative and unnecessary testing; improve patient safety by reducing medical errors; and increase our understanding of the clinical, safety, quality, financial, and organizational value of health IT.

DAV believes the intent of S. 1296 is laudable; however, we ask the Committee ensure the measure is consistent with the pertinent provisions in the 2014 NDAA awaiting consideration by the Senate. Moreover, we urge the Committee to consider the current capabilities of the Interagency Program Office (IPO), which would likely be responsible for meeting the requirements contained in S. 1296. The IPO was established by Congress in Section 1635 of Public Law 110–181, the 2008 National Defense Authorization Act as the office accountable for developing and implementing the health information sharing capabilities for DOD and VA. Staffing challenges within the IPO have been an issue. As of January 2013, the IPO was staffed at about 62 percent of the 236 employees assigned by both departments, according to a February 2013 Government Accountability Office report, which also noted hiring additional staff is one of the biggest challenges.¹

S. 1361, THE WORLD WAR II MERCHANT MARINER SERVICE ACT

S. 1361 would direct the Secretary of Homeland Security to accept additional documentation when considering the application for veteran status of an individual who performed service as a coastwise merchant seaman during World War II.

DAV does not have a resolution on this issue and takes no position on S. 1361.

S. 1399, TO EXTEND THE INTEREST RATE LIMITATION ON DEBT ENTERED INTO DURING MILITARY SERVICE TO DEBT INCURRED DURING MILITARY SERVICE TO CONSOLIDATE OR REFINANCE STUDENTS LOANS INCURRED BEFORE MILITARY SERVICE

S. 1399 would amend the Servicemembers Civil Relief Act to extend the interest rate limitation on debt entered into during military service to debt incurred during military service to consolidate or refinance students loans incurred before military service.

DAV does not have a resolution on this issue and takes no official position on this legislation.

S. 1411, THE RURAL VETERANS HEALTH CARE IMPROVEMENT ACT OF 2013

S. 1411 would require the Office of Rural Health of the Veterans Health Administration to update its “Strategic Plan Refresh,” a document VA issued in 2012 that reviewed VA’s rural health expenditures, and laid out VA’s plans for rural health developments over the near term, and for other purposes. Our members have approved DAV Resolution No. 211, calling on Congress and VA to support sufficient resources for VA to improve health care services for veterans living in rural or remote areas; thus, we support this bill.

S. 1434, TO RENAME THE JUNCTION CITY, KANSAS COMMUNITY-BASED OUTPATIENT CLINIC

S. 1434 would designate the Junction City Community-Based Outpatient Clinic located at 715 Southwind Drive, Junction City, Kansas, as the Lieutenant General Richard J. Seitz Community-Based Outpatient Clinic.

As a local issue, DAV does not have a national position on the matter.

S. 1471, THE ALICIA DAWN KOEHL RESPECT FOR NATIONAL CEMETERIES ACT

S. 1471 would authorize the Secretary of Veterans Affairs and the Secretary of the Army to reconsider decisions to inter or honor the memory of a person in a national cemetery.

¹*Long History of Management Challenges Raises Concerns about VA’s and DOD’s New Approach to Sharing Health Information*, Government Accountability Office, February 27, 2013. Washington, DC.

DAV does not have a resolution on this issue and takes no official position on this bill.

S. 1540, TO REMOVE A LEGAL OBSTACLE THAT EFFECTIVELY PREVENTS STATE VETERANS HOMES FROM APPLYING FOR FEDERAL GRANTS TO SUPPORT HOMELESS VETERANS PROGRAMS

S. 1540 was introduced in order remove a legal obstacle that effectively prevents state veterans homes from applying for Federal grants to support a homeless veterans program.

State veterans homes are a partnership between the Federal Government and the States, with the Federal Government providing construction grants that may cover up to 65 percent of the cost to build and maintain the homes, and states providing the balance. In addition, the Federal Government pays a per diem covering approximately one-third of the cost to care for qualified veterans under three authorized programs: nursing home care, domiciliary care and adult day health care.

Currently, some state veterans homes have underutilized bed capacity in their domiciliary program, a portion of which could be repurposed for homeless veterans programs. A few state homes that are well positioned to provide and coordinate the multitude of health care and supportive services required by homeless veterans have expressed an interest in applying for grants operate such a program. However under current law, state homes are authorized to use their Federal support only for the three aforementioned programs and if a state home were to operate a homeless veterans program, the Federal Government could seek to recapture construction grant funding provided over the prior twenty years. Since no state home could afford to pay that high a financial penalty, this provision effectively prevents them from using excess capacity for operating a homeless veterans program.

S. 1540 seeks to resolve this problem by amending the recapture provisions of title 38, United States Code, section 8136, with an exemption for state homes that receive a contract or grant from VA for residential care programs, including homeless veterans programs. The change would remove the financial obstacle preventing some state homes from applying for Federal grants to support homeless veterans, such as through VA's Health Care for Homeless Veterans program, but the decision to award the grant (or contract) would remain solely with VA as the grantor. It would be up to VA to determine whether the state home had sufficient excess capacity and was capable of operating a successful homeless veterans program.

By allowing state homes with excess bed capacity in their domiciliary programs to repurpose a portion of that existing space to support homeless veterans, this legislation would allow some additional options for homeless veterans in a cost-effective manner.

In line with DAV Resolution No. 165, which calls for sustained sufficient funding to improve services for homeless veterans, DAV supports the intent of this legislation; however, we urge the Committee ensure the legislation allows for the recapture of the portion of grants to state homes if so provided for the costs of construction, renovation, or acquisition of a building for use as service centers or transitional housing for homeless veterans under VA's Homeless Providers Grant and Per Diem Program.

S. 1547, THE VETERANS DIALYSIS PILOT PROGRAM REVIEW ACT OF 2013

VA estimates show that in FY 2011, approximately 35,000 veterans enrolled in the VA health care system were diagnosed with end-stage renal disease (ESRD) reflecting a higher prevalence in the VA population than in the general U.S. population.² Initiated based on the rapidly rising cost of VA paid hemodialysis treatment in non-VA facilities and the high rates of morbidity and mortality of veteran patients with ESRD, several VA studies of this veteran patient population and paid for or directly provided dialysis therapy have been conducted.³

The May 23, 2012 Government Accountability Office (GAO) report on VA's Dialysis Pilot states VA had not fully developed performance measures for assessing the pilot locations⁴ even though the Department has already begun planning for the expansion of the dialysis pilot. Further, GAO indicated that such an expansion "should

² *Comparison of outcomes for veterans receiving dialysis care from VA and non-VA providers*, Wang et al., BMC Health Services Research 2013, 13:26.

³ *Comparing VA and private sector healthcare costs for end-stage renal disease*, Hynes et al., Medical care 2012, 50(2):161–170.

⁴ Veterans Affairs (VA) medical centers (VAMC) in Durham and Fayetteville, North Carolina started June 2011; Philadelphia, Pennsylvania started October 2012; and Cleveland, Ohio started July 2013.

not occur until after VA has defined clear performance measures for the existing pilot locations and evaluated their success.”

This measure would limit the expansion of VA’s dialysis pilot program beyond current locations, require an independent analysis of the pilot, and to submit a report to Congress based on the analysis.

While Congress has been focused on VA’s actions to address the growing demand of dialysis therapies depicted in recent committee reports,⁵ DAV is concerned that the discussion on VA’s dialysis pilot and on the Department’s purchased or provided dialysis therapy in general appears to be centered on cost and we find there is not sufficient emphasis on the veteran patient.

Certainly, ESRD patients are one of the most resource-intensive patient populations in the VA health care system. However, the burden of hemodialysis is extreme to veteran patients. It is a life-altering event that has implications for the veteran’s health, lifestyle, and livelihood. Veterans diagnosed with ESRD are often prescribed and must receive dialysis treatments. These treatments are time intensive for veterans and typically require three outpatient treatments per week that each last about 4 hours for the rest of their lives unless they receive a kidney transplant.

As one of *The Independent Budget* veterans service organizations (IBVSOs), coordinating care among the veteran, dialysis clinic, VA nephrologists, and VA facilities and physicians is essential to improving clinical outcomes and reducing the total costs of care. The benefits of an integrated, collaborative approach for this population have been proven in several Centers for Medicare and Medicaid Services demonstration projects and within private-sector programs sponsored by health plans and the dialysis community. Such programs implement specific interventions that are known to avoid unnecessary hospitalizations, which frequently cost more than the total cost of dialysis treatments. These interventions also focus on behavioral modification and motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower costs could be substantial for VA and veteran patients.

We understand that some community dialysis providers are piloting the integrated care management concept among their veteran population. The IBVSOs believe that VA should provide integrated care management in this pilot program that can test and demonstrate the value of such an approach to VA and the veterans it serves.

S. 1556, TO MODIFY AUTHORITIES RELATING TO THE COLLECTIVE BARGAINING OF
EMPLOYEES IN THE VHA

S. 1556 would amend title 38, United States Code, to modify authorities relating to the collective bargaining of employees in the Veterans Health Administration.

This bill would restore some bargaining rights for clinical care employees of the VHA that were eroded by the former Administration and through subsequent Federal court decisions. The bill would strike subsections (b), (c) and (d) of section 7422 of title 38, United States Code. Enactment of the bill would have the effect of authorizing employee representatives of recognized bargaining units to negotiate with VHA management over matters of employee compensation and conditions of employment other than their rates of basic pay. This feature is an important one in that locality pay elements and performance pay increments are subject only to VA’s internal policymaking determinations. Recognized VA employee representatives have been subjectively excluded from participating in these decisions based on VA’s interpretation that section 7422 broadly blocks any negotiation due to its potential negative impact on the quality of care of veterans.

We believe labor organizations that represent employees in recognized bargaining units within the VA health care system, including in its professional units, have an innate right to information and reasonable participation that result in making the VA health care system a workplace of choice, and in particular, to fully represent VA employees on issues impacting their conditions of employment.

Congress passed section 7422, title 38, United States Code, in 1991, in order to grant specific bargaining rights to labor in VA professional units, and to promote effective interactions and negotiation between VA management, and its labor force recognized representatives concerned about the status and working conditions of VA physicians, nurses and other direct caregivers appointed under title 38, United States Code. In providing this authority, Congress granted to VA employees and their recognized representatives a right that already existed for all other Federal

⁵ House Appropriations Report 112–094 page 41, May 213, 2011 and House Appropriations Reports 112–491, pages 39–40, May 23, 2012.

employees appointed under title 5, United States Code. Nevertheless, Federal labor organizations have reported that VA severely restricts the recognized Federal bargaining unit representatives from participating in, or even being informed about, a number of human resources decisions and policies that directly impact conditions of employment of the VA professional staffs within these bargaining units. We are advised by labor organizations that when management actions are challenged, VA officials (many at the local level) have used subsections (b), (c) and (d) of section 7422 as a statutory shield to obstruct any labor involvement to correct or ameliorate the negative impact of VA's management decisions on employees, even when management is allegedly not complying with clear statutory mandates (e.g., locality pay surveys and alternative work schedules for registered nurses, physician locality pay compensation panels, etc.).

We believe this bill, which would rescind VA's ability to refuse to bargain on matters of employment conditions and elements of compensation other than rates of basic pay embedded in law, is an appropriate remedy to address part of the bargaining problem in the VA's professional ranks. We understand recently VA has given Federal labor organizations some indication of additional flexibility in negotiating labor-management issues such as some features of supplemental compensation, and we are hopeful that this change signals a new trend in these key relationships that directly affect sick and disabled veterans.

While DAV has not received a specific resolution from our membership related to the issues contained in this bill, we would not object to its enactment, while continuing to hope that VA and Federal labor organizations can find a sustained basis for compromise.

S. 1558, TO CARRY OUT A PROGRAM OF OUTREACH FOR VETERANS TO INCREASE THEIR ACCESS AND USE OF FEDERAL, STATE, AND LOCAL PROGRAMS PROVIDING COMPENSATION FOR SERVICE IN THE ARMED FORCES

S. 1558 would require the Secretary of Veterans Affairs to carry out a program of outreach for veterans to increase their access and use of Federal, State, and local programs providing compensation for service in the Armed Forces and the awareness of such programs by veterans and their eligibility for such programs.

Although DAV does not have a resolution on this particular matter, we currently provide such outreach to veterans and, therefore, we would not oppose passage of this legislation. The intent of this bill is to make veterans aware of the services and benefits from the VA that they have earned, which will increase the use of VA benefits and services. While we certainly agree and support the increased awareness, this will undoubtedly lead to increased demands placed upon the VA. Congress must ensure that VA has the adequate resources to handle the increase in demand.

If the enhanced outreach is successful and the demand too great, then this endeavor would cause a negative impact on VA and the veterans it serves.

S. 1559, THE BENEFITS FAIRNESS FOR FILIPINO VETERANS ACT OF 2013

S. 1559 would amend title 38, United States Code, to modify the method of determining whether Filipino veterans are United States residents for purposes of eligibility for receipt of the full-dollar rate of compensation under the laws administered by the Secretary of Veterans Affairs.

DAV does not have a resolution on this issue and takes no position on S. 1559.

S. 1573, THE MILITARY FAMILY RELIEF ACT

S. 1573 would amend section 1318 of title 38, United States Code, to provide for the payment of temporary compensation to a surviving spouse of a veteran upon the death of the veteran. Essentially this legislation is aimed at providing temporary death benefits to a surviving spouse for six months, without regard to whether that individual has submitted a claim for such compensation if, at the time of the veteran's death the veteran was in receipt or entitled to receive compensation for a service-connected disability continuously rated as total for not less than one year immediately preceding the veteran's death.

Specifically, if enacted, S. 1573 would allow a surviving spouse to receive payment of survivors benefits temporarily, for six months, with no lapse in time from the discontinuance of disability compensation upon the veteran's death. Given the current backlog of pending claims within the Veterans Benefits Administration (VBA), surviving spouses are left for months upon months with no income between the time of the veterans' death (and resultant loss of disability compensation) and the time dependency and indemnity compensation (DIC) benefits are awarded.

Under section 1318 of title 38, United States Code, certain surviving spouses may be entitled to DIC if at the time of the veteran's death, the veteran was continu-

ously rated totally disabled for a period of five years within discharge or release from active duty; the veteran was continuously rated totally disabled for a period of 10 years or more; or the veteran was continuously rated totally disabled for a period of one year if the veteran was a former prisoner of war.

Generally, claims submitted for DIC that meet any of the aforementioned eligibility criteria can be processed by VBA very quickly because little to no development is required. However, because of the dire backlog of claims within VBA, qualified surviving spouses are left to languish for unacceptably long periods of time with no income. Even if the surviving spouse were to file a qualifying claim for DIC pursuant to Section 1318 of title 38, United States Code, under the more expedient FDC process, a lapse in payment and loss of vital income would still exist. S. 1573 is directed specifically at bridging the gap of benefits between the veteran's death and the time DIC is awarded. While this measure would provide DIC only temporarily for six months, it would ease the burden the veteran's death and immediate loss of vital income while VBA finally processes the claim.

In accordance with DAV Resolution No. 001, DAV supports enactment of S. 1573.

DRAFT BILL, TO UPDATE THE SERVICE DISABLED INSURANCE PROGRAM TO BASE PREMIUM RATES ON THE COMMISSIONER'S 2001 STANDARD ORDINARY MORTALITY TABLE INSTEAD OF THE COMMISSIONER'S 1941 STANDARD ORDINARY TABLE OF MORTALITY

This bill would amend title 38, United States Code, to update the Service Disabled Insurance program to base premium rates on the Commissioner's 2001 Standard Ordinary Mortality table instead of the Commissioner's 1941 Standard Ordinary Table of Mortality. DAV is pleased to see the introduction of this draft Senate bill.

It is strongly supported by our organization and has been adopted for decades as a formal resolution by DAV delegates. Also, the IBVSOs have encouraged Congress to adjust these premium rates rather than continue the practice of using an antiquated formula that has been disproportionate to industry standards. This premium inequity has persisted amongst disabled veterans for so many years with the monthly cost of this insurance negating the overall value of the benefit itself.

DAV strongly encourages this Committee to work with your colleagues and with the House of Representatives to ensure favorable consideration of this legislation. DAV also welcomes the opportunity to work with Congress to ensure the enactment of this measure, which will have a lasting and positive impact on our Nation's disabled veterans and their families now and into the future.

DRAFT BILL, TO PROVIDE REPLACEMENT AUTOMOBILES FOR CERTAIN DISABLED VETERANS AND MEMBERS OF THE ARMED FORCES

This bill would amend title 38, United States Code, to provide replacement automobiles for certain disabled veterans and members of the Armed Forces. This measure, if enacted, would amend section 3903 allowing qualified disabled veterans the opportunity to utilize this vital program up to three times, rather than the currently allowed one time, and increase the current amount from \$18,900 to \$30,000. This measure will allow a qualified disabled veteran the ability to use the benefit up to two times beyond the initial use of the grant with an aggregate amount of \$30,000 available to the veteran.

Not only has the issue of increasing the amount of the automobile grant benefit been a long-standing issue for DAV, other veterans service organizations (VSOs) have also sought to have the amount of this vital benefit increased. DAV, joined with the other IBVSOs, have urged Congress to expand the automobile grant benefit by allowing previous recipients of a much lesser amount of \$11,000, \$8,000 or even less, to be able to receive a supplemental auto grant for the difference between what the original automobile grant and the current amount.

For example, the VA provides financial assistance in the form of grants to eligible veterans toward the purchase of a new or used automobile to accommodate a veteran or servicemember with certain disabilities that resulted from a disabling condition incurred or aggravated during active military service. In December 2011, this one-time auto grant was increased from \$11,000 to \$18,900, thus giving service-disabled veterans who need a modified vehicle increased purchasing power. While there are veterans who have not yet used the grant, veterans who have exhausted the grant are left to replace modified vehicles, once those vehicles have surpassed their useful life, at their own expense and at a higher cost than the first adapted vehicle due to inflation.

Additionally, last year the Department of Transportation reported the average life span of a vehicle is 12 years, or about 128,500 miles. The cost to replace modified vehicles can range from \$40,000 to \$65,000 new, and \$21,000 to \$35,000 used, on average. These tremendous costs, compounded by inflation, present a financial hard-

ship for many service-disabled veterans who need to replace their primary mode of transportation once it exceeds its expected life.

As such, in accordance with DAV resolution No. 170, DAV supports enactment of this draft legislation as it will expand the vital automobile grant benefit by allowing multiple uses while increasing the current amount from \$18,900 to an aggregate amount of \$30,000.

DRAFT BILL, THE VETERANS HEALTH CARE ELIGIBILITY EXPANSION ACT OF 2013

Section 2 of this measure would amend title 38, United States Code, section 1710 authorizing VA to provide health care to all veterans not currently enrolled in the VA health care system provided they meet other statutory requirements, including section 5303, availability of appropriations, agreeing to pay copayments, etc.

In amending section 1710 however, this new authority would require VA provide nursing home care to veterans described under the new paragraph (3) of subsection (a) while giving VA the discretion to provide nursing home care to veterans described under paragraph (2) of subsection (a).

(2) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services, and *may furnish nursing home care*, which the Secretary determines to be needed to any veteran—

(3) In the case of a veteran who is not described in paragraphs (1) and (2), the Secretary *shall* subject to the provisions of subsections (f) and (g), furnish hospital care, medical services, and *nursing home care* which the Secretary determines to be needed. [Emphasis added]

DAV National Resolution No. 186 supports top priority access for service-connected veterans within the VA health care system.

For purposes of equity, we recommend language amending paragraph (2) to state that the Secretary shall furnish hospital care, medical services, and nursing home care that the Secretary determines to be needed to any veteran under subparagraphs A through G.

Section 3 would amend title 38, United States Code, section 1705 requiring VA allow for the enrollment by December 31, 2014, of noncompensable service-connected veterans and nonservice-connected veterans not currently permitted to enroll in the VA health care system and who do not have access to health insurance except through state-based health insurance exchanges established according to the Patient Protection and Affordable Care Act.

DAV has no resolution to support this section and would not object to its favorable consideration as long as sufficient resources are in place at the time this enrollment takes effect.

Section 4 seeks to extend the eligibility for enrollment in the VA health care system from 5 to 10 years following discharge for a combat veteran discharged after January 27, 2003.

DAV has no specific resolution but the provision appears beneficial, thus we would not oppose favorable consideration of this section.

Section 5 intends to relocate section 1710(a)(4), which this measure proposes to eliminate, and by adding a new subsection (c) in section 1707.

DAV has no resolution and would not object to its favorable consideration. However, we note the requirements of VA in providing required nursing home care under section 1710A is due to expire December 31, 2013. We also note enactment of this provision would require technical changes in other sections of title 38 referencing subsection 1710(a)(4).

Section 6 would insert a new section (1729B) in title 38 to establish the “Medicare VA reimbursement program” for the purposes of recovering from the Department of Health and Human Services those costs to VA from providing treatment for a non-service-connected condition to a Medicare-eligible veteran.

DAV has no resolution on this section and takes no formal position. However, notwithstanding the “Sense of Congress” provision, which is not enforceable on Congress or the Administration, that reimbursements received by VA from HHS⁶ “should not be” used to reduce VA discretionary appropriations, history shows that third-party reimbursements have indeed been used to offset VA medical care discretionary appropriations despite the original intent.

⁶ § 1729B (c)(5) “Any payment made to the Department under this subsection shall be deposited in the Department of Veterans Affairs Medical Care Collections Fund under section 1729A of this title.”

History has also shown that VA does not have a good record of meeting projected amounts to be collected from reimbursements and must then operate a health care system with less funds than needed to meet the demand for care and services.

DRAFT BILL, THE ENHANCED DENTAL CARE FOR VETERANS ACT OF 2013

This measure would authorize VA to establish a three-year pilot program in at least 16 locations to assess the feasibility and advisability of furnishing dental care to veterans enrolled in the VA health care system who are not eligible under current authorities for VA dental care. In addition, this bill would extend for an additional two years the VA Dental Insurance Program (VADIP) for veterans and survivors and dependents of veterans mandated under Section 510 of Public Law 111–163.

The legislation also requires VA to establish a mechanism to add any dental care treatment information provided by private providers under VADIP in VA's Computerized Patient Record System (CPRS). Until recently, the discretionary nature of receiving any treatment information from a non-VA provider and electronically associating it with a veteran treatment file in CPRS has traditionally not been successful particularly if there is no requirement that submission of such records to VA was a condition to receive payment from the Department or that it is required by VA policy to include such records in CPRS. While we are supportive of the intent in Section 5, we believe there will be limited success without an incentive or disincentive for the transmission or receiving end of such information.

DAV is pleased to support this measure based on DAV Resolution No. 072, supporting legislation to amend title 38, United States Code, section 1712, to provide outpatient dental care to all enrolled veterans. However, DAV opposes subsection (g), the copayment provision under the VA provided dental care pilot program in accordance with our Resolution No. 194, calling for the elimination or reduction of VA health care out-of-pocket costs for service-connected disabled veterans.

DRAFT BILL, THE MENTAL HEALTH SUPPORT FOR VETERANS FAMILIES AND CAREGIVERS ACT OF 2013

The Mental Health Support for Veterans Families and Caregivers Act of 2013 would require the Secretary of Veterans Affairs to conduct an education program and peer support program for family members and caregivers of veterans with mental health disorders. The goal of the measure is to educate and train the family members and caregivers in how to cope with mental health disorders in veterans and would take place over a four-year period, with the Secretary being authorized to extend the duration of the education program for an additional four years. Eligible veterans are those who are enrolled in the VA health care system.

The bill would mandate VA to establish the education program in at least 10 VA medical centers (VAMCs), Community-Based Outpatient Clinics (CBOCs), and Vet Centers. Additionally, the Secretary must consider the feasibility of selecting locations in rural areas, areas not in close proximity to an active duty location and areas in different geographic locations. Two years after the start of the program, the Secretary would be required to expand locations to at least 10 more VAMCs, 10 more CBOCs, and 10 more Vet Centers.

In order to facilitate the program, the Secretary is required to enter into contracts with nonprofit entities with experience in mental health education and outreach to include work with children, teenagers and young adults. These groups must use high quality, relevant and age-appropriate information in their educational materials and coursework. The nonprofit entities must work with agencies, departments, nonprofit mental health organizations, early childhood educators and mental health providers to develop the educational programming, materials and coursework. The Secretary would give priority entering into contracts with entities that also use Internet technology for delivery of course content in order to expand the availability of support services, especially in rural areas.

The education component of the program would consist of at least 10 weeks of general education on different mental health disorders with information on understanding experiences of persons suffering from the disorders; techniques for handling crisis situations and administering mental health first aid; techniques for managing stress affiliated with living with a person with a mental health disorder; information on additional services available for family members and caregivers through VA or community organizations as well as mental health providers.

The instructors of the education program must be proficient in the course of education and able to prove their level of proficiency to the Secretary. Two years after the program has begun, those who have successfully completed the course of education as well as any additional training that may be required, may act as an instructor in the education course. The Secretary will select mental health care pro-

viders to monitor the instruction of the education program along with primary care providers. The mental health providers will monitor instructors by meeting with them quarterly, and at a minimum of twice a year will submit a report on the progress of the instruction provided in the education program to the Secretary.

The peer support program will be conducted at the same locations the Secretary chooses for the education program and will consist of group meetings at least twice each calendar quarter between a peer support coordinator, family members and caregivers of eligible veterans on matters related to coping with mental health disorders in veterans. The medical facility director of each participating facility shall select an individual who has completed a course of education and maintains proficiency to serve as a peer support coordinator. A mental health care provider selected by the Secretary would be required to mentor each peer support coordinator and will meet with them quarterly to monitor progress of the program, and at a minimum of twice a year will submit a report on the progress of the peer support program to the Secretary.

The measure would also require the Secretary to conduct a comprehensive and statistically significant survey of individuals who have participated in the education and peer support programs to include their level of satisfaction, perceived effectiveness and applicability of the programs. This information is to be included in a mandated annual report due no later than one year after the start of the education program, and no later than September 30 of every following year until 2017. In addition to the survey results, the report must include the number of participants in each program, analysis of the surveys, summary of feedback from the mentors and monitors, and the degree to which the veterans and family members and caregivers are aware of the eligibility requirements for enrollment in both programs. The report must also note any plans for expansion of the programs and interim findings and conclusions of the Secretary with respect to the success of the programs. The bill requires the mandated report to be submitted to the Committees on Veterans' Affairs of the Senate and House.

The final report would be due to the Committees on Veterans' Affairs of the Senate and House no later than one year after the completion of the education program regarding the feasibility and advisability of the education and peer support programs to include analysis of the surveys, viability of continuing the education program without entering into contracts and instead using peer support coordinators selected as instructors of the education course as well as comments on expanding both programs.

In accordance with DAV Resolution No. 166, DAV is pleased to support the Mental Health Support for Veterans Families and Caregivers Act of 2013. DAV Resolution 166 calls on the Secretary of Veterans Affairs to establish appropriate and effective programs to ensure that veterans who are enrolled in VA health care receive adequate care for their wounds and illnesses, including mental health-related illnesses, and, when appropriate, family members—whether family caregivers, spouses or other family dependents—receive necessary counseling, including psychological counseling, training and other mental health support services authorized by law to aid in the recovery of veterans.

VA treats a large patient population of veterans suffering from chronic effects of PTSD, depression and other serious mental illnesses. Many of these veterans suffer marriage and relationship breakdown, under-employment or loss of employment, financial hardship, social alienation and even homelessness. When a veteran experiences emotional distress and or mental decompensation, the consequences of that behavioral health event often fall directly on the veteran's family members and caregivers. Experts argue that support of family members and caregivers is often vital to a veteran's gaining and maintaining emotional stability and eventual recovery from mental illness.

Currently, title 38, United States Code, subsection 1712A(b)2 authorizes the VA Readjustment Counseling Service, through its Vet Center program, to provide psychological counseling and other necessary mental health services to family members of war veterans under care in such Vet Centers, irrespective of service-connected disability status. Section 301 of Public Law 110–387 authorizes marriage and family counseling in VA facilities to address the needs of veterans' families, including spouses and other dependent family members of veterans who are experiencing mental health challenges with attendant marital or family difficulties. Public Law 111–163 authorizes a wide array of support, care and counseling services for personal caregivers of severely injured or ill veterans from all eras of military service.

Additionally, title 38, United States Code, section 1782 authorizes a program of counseling, training, and mental health services, including psychological support, for immediate family members of disabled veterans who need care for service-connected disabilities; who have service-connected disabilities rated at 50 percent or more dis-

abling; who were discharged or retired from the Armed Forces for injuries or illnesses incurred in line of duty; who are World War I or Mexican Border Period veterans; who were awarded the Purple Heart; who are former prisoners of war; who were exposed to radiation or toxic substances; or, who are unable to defray the expenses of their care.

This measure would expand education, training and psychological support, for family members and caregivers of enrolled veterans with mental health disorders.

DRAFT BILL, THE MEDICAL FOSTER HOME ACT OF 2013

This bill would authorize the Secretary of Veterans Affairs to cover the costs associated with the care of veterans at medical foster homes.

VA inspects and approves Medical Foster Homes, which are private homes with a trained caregiver providing needed services to a few individual residents. A Medical Foster Home may be appropriate for veterans who would otherwise be placed in a nursing home because they lack the support network necessary to remain in their own home.

VA ensures the caregiver is both well trained to deliver VA's planned care for the veteran and is on duty 24 hours a day, 7 days a week. While living in a Medical Foster Home, veteran residents are enrolled in the VA Home Based Primary Care program and care is provided by an interdisciplinary team that offers a broad array of supportive services.

DAV is pleased with VA's innovation by offering medical foster homes as part of its long-term care program. While patient participation in this program is voluntary, it yields exceedingly high satisfaction among veteran residents. In addition, because of its low cost, many VA facilities perceive this program as a cost-effective alternative to nursing home placement and it is gaining popularity based on the expansion of this program over the last several years.

However, based on DAV Resolution No. 198, supporting legislation to expand the comprehensive program of long-term services and supports (LTSS) for service-connected disabled veterans, and as part of the *IB*, DAV is greatly concerned that veterans living in medical foster homes are required to use personal funds, include VA disability compensation, as payment.

Because this program operates under VA's community residential care authority, veterans in medical foster home programs have to pay for their care, which range from about \$50 to as much as \$150 a day. Even veterans who are otherwise entitled to nursing home care fully paid for by VA, whether it is under the law or by VA's policy must pay to reside in a Medical Foster Home. Moreover, service-connected veterans who do not have the resources to pay a medical foster home caregiver may not avail themselves of such an important benefit.

We thank the Chairman for introducing this measure, which would give VA the authority to pay for those costs service-connected veterans must currently pay out-of-pocket to reside in a VA approved medical foster home.

DAV is pleased to support the intent of this bill; however, because current statutory authority prohibits VA from meeting its mandatory obligations in providing long-term services and supports to service-connected disabled veterans, we believe the intent of this legislation should be codified.

DRAFT BILL, THE SCRA ENHANCEMENT AND IMPROVEMENT ACT OF 2013

The SCRA Enhancement and Improvement Act of 2013 would amend the Servicemembers Civil Relief Act to extend the interest rate limitation on debt entered into during military service to debt incurred during military service to consolidate or refinance students loans incurred before military service.

DAV does not have a resolution on this issue and takes no official position, but would not oppose enactment of such legislation.

DRAFT BILL, THE IMPROVED COMPENSATION FOR HEARING LOSS ACT OF 2013

The Improved Compensation for Hearing Loss Act of 2013 would require the Secretary of Veterans Affairs to submit reports on the provision of services by the VA to veterans with hearing loss and other auditory system injuries and the measures that can be taken jointly by the VA and the DOD with respect to hearing loss and other auditory system injuries.

Specifically, if enacted, this proposed legislation would allow the Secretary one year from the date of such enactment to report to Congress on the actions taken to implement the directives in Public Law 107-330, the Veterans Benefits Act of 2002, with respect to a longitudinal study of hearing loss and tinnitus since World War II, and the implementation of findings and recommendations of the pursuant

comprehensive 2006 report by the Institute of Medicine titled, “Noise and Military Service: Implications for Hearing Loss and Tinnitus.”

This measure requires the Secretary’s report to include an evaluation as to the number of veterans who had a military occupational specialty (MOS) not included in the Duty Military Occupational Specialty Noise Exposure Listing (MOS List) that are precluded from receiving hearing loss benefits from VA. This measure also requires the Secretary to report the number of veterans who had an MOS listed on the MOS List that were granted and denied benefits for hearing loss; and of those veterans with an MOS not listed on the MOS List, the number that were granted and denied entitlement to hearing loss benefits, as well as the number of those denied that were successfully granted on appeal.

While this proposed legislation is one of reporting requirement in nature, of particular interest to DAV is the requirement for the Secretary to provide an explanation of the rationale for the practice of not issuing a compensable rating for hearing loss that is severe enough to necessitate the use of hearing aids. This particular provision in the proposed legislation is directly in line with a long-standing DAV resolution, as well as in consensus with the other Independent Budget VSOs, as it has been recognized that certain veterans may suffer from hearing loss to the degree of requiring a prescribed hearing aid, but are not able to receive compensation.

In fact, the VA Schedule for Rating Disabilities (VASRD) contained in title 38, Code of Federal Regulations, part 4 does not provide a compensable rating for hearing loss at certain levels severe enough to require the use of hearing aids. The minimum disability rating for any hearing loss severe enough to require use of a hearing aid should be 10 percent, and the VASRD should be amended accordingly.

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment and the disadvantages of artificial hearing restoration, hearing aids negatively affect the wearer’s physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of VA disability compensation that ratings are not offset by the function artificially restored by a prosthetic device.

For example, a veteran receives full compensation for amputation of a lower extremity although he or she may be able to ambulate with a prosthetic limb. Additionally, a review of title 38, Code of Federal Regulations, Part 4 [VASRD] shows that all disabilities for which treatment warrants an appliance, device, implant, or prosthetic, other than hearing loss with hearing aids, receive a compensable rating.

Assigning a compensable rating for medically prescribed hearing aids would be consistent with minimum ratings provided throughout the VASRD. Such a change would be equitable and fair.

While DAV appreciates the proposed legislation requiring the Secretary to provide an explanation, we believe this provision would merely allow VA the opportunity to prolong this inequitable issue. In accordance with DAV Resolution No. 111, DAV recommends this provision of the proposed legislation be changed from requiring the Secretary to provide an explanation to that of amending the VASRD to provide a minimum 10 percent disability rating for any service-related hearing loss medically requiring a hearing aid.

Although we do not have a resolution to support the other reporting requirements of this proposed legislation, DAV is not opposed enactment of those provisions, provided they do not overburden VA at a time where transformation of the claims process and reducing the backlog of pending disability claims is paramount.

DRAFT BILL, THE SURVIVORS OF MILITARY SEXUAL ASSAULT AND DOMESTIC ABUSE ACT OF 2013

The Survivors of Military Sexual Assault and Domestic Abuse Act of 2013 would expand subsection (a) of section 1720D of title 38, United States Code, and authorize the VA to provide counseling and treatment for sexual trauma to members of the Armed Forces including the National Guard and Reserves to aid in their overcoming psychological trauma. A referral will not be required before an individual receives counseling and care. Some technical aspects of the measure include amending the law to be gender neutral.

Section 3 of the bill would require the VA Secretary, no later than 540 days after enactment of the Act, to develop and implement a screening mechanism to be used when veterans seek health care services from VA to identify if the veteran has been a victim of domestic abuse. The purpose of this provision is to improve treatment of the veteran and assess prevalence of domestic abuse in the veteran population. Domestic abuse, in part, is defined as behavior that constitutes a pattern of physical or emotional abuse, economic control or interference with personal liberty, or a violation of Federal or state law involving the attempted, threatened, or actual use of

force or violence against the person, in addition to a violation of a protective order. In order to qualify as domestic abuse, the behavior is committed by a current or former spouse or domestic partner, or a person that shares a child with the individual, is a current or former intimate partner that shares or has shared a common residence or is a caregiver of the individual as defined in section 1720G(d) of title 38, United States Code, or in any other type of relationship with the individual that the Secretary may specify for this purpose.

Section 4 of the legislation would require the VA Secretary, within a year after enactment of the Act, to submit a report to the Committees on Veterans' Affairs of the Senate and House and detail the treatment and services available from VA for male veterans who experience military sexual trauma (MST) compared to the treatment and services available to women veterans who experience MST. The Secretary would also be required to include a report on domestic abuse among veterans that specifies the types, outcomes, and circumstances of domestic abuse incidents reported by veterans over the two-year period preceding the submission of the report as well as a summary of the treatments available from VA for sufferers of domestic abuse and whether an incident of MST experienced after the age of 18 may increase the risk for domestic abuse along with any other issues the Secretary deems appropriate.

Additionally, within a year after enactment of this Act and annually thereafter for five years, the VA/DOD Joint Executive Committee would be required to submit a report on MST and domestic abuse that details the processes and procedures utilized by VA and DOD to facilitate transition of treatment of those who have experienced either of one these to include treatment provided by both Departments. The report must also include a description and assessment of VA/DOD collaboration assisting veterans in filing claims for disabilities related to MST or domestic abuse, including permitting veterans access to information and evidence necessary to develop or support such claims.

The continued prevalence of sexual assault in the military is alarming and often results in lingering physical, emotional or chronic psychological symptoms in assault survivors. The DOD's Office of Sexual Assault Prevention and Response (SAPRO) reports that over 3,000 sexual assaults are reported each year across the military services and estimates that approximately 87 percent of all sexual assaults go unreported, therefore approximating more than 26,000 sexual assaults occur each year in the military services. Likewise, more than 20 percent of women and over one percent of men enrolled in the VA health care system report they had experienced military sexual trauma (MST). MST-related outpatient treatment encounters total nearly 800,000 clinic visits each year in the VA.

For these reasons, DAV is pleased to support the Survivors of Military Sexual Assault and Domestic Abuse Act of 2013. DAV Resolution No. 125, in part, urges VA to continually improve its MST treatment programs. DAV wants to ensure all MST survivors, male and female, gain open access to the specialized treatment programs and services they need to fully recover from sexual trauma that occurred in military service. We appreciate the intent of the bill to improve better collaboration between DOD and VA, specifically related to transition from military service to veteran status, as it is essential in achieving this goal. Due to the stigma and sensitive and personal nature of sexual assault, coupled with the unique and complex military hierarchy, rules and regulations that servicemembers are subjected to, it appears it would be extremely beneficial for active duty servicemembers, including National Guard and Reserve troops, to have access to MST counseling and care from VA. Although DAV does not have a specific resolution related to domestic abuse screening or required reports, we have no objection to those provisions in the bill.

DAV also suggests the Committee consider adding a provision in the bill related to MST care and beneficiary travel reimbursement. As a result of VA clinical determinations, some veterans are referred to VA medical facilities other than their local facilities or closest Veterans Integrated Service Network to receive the specialized MST care they need. The VA Office Inspector General (IG) conducted a healthcare inspection of inpatient and residential programs for female veterans with mental health conditions related to MST. The IG found that obtaining authorization for travel funding was frequently cited as a problem for patients and staff.

According to the IG, the VA's current policy in beneficiary travel indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing comparable service. The IG points out that this Directive is not aligned with the MST policy that states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location. If a VA clinician determines an MST survivor needs specialized care from a VA MST inpatient facility, VA's beneficiary travel policy may serve to obstruct access to that unique resource, or force an MST survivor to self-pay all

travel costs in order to gain access to these specialized services. For these reasons, DAV supports legislation to change beneficiary travel policies to meet the specialized clinical needs of veterans receiving MST-related treatment in accordance with DAV Resolution 125.

DRAFT BILL, TO EXPAND AND FACILITATE COMPENSATION OF VETERANS FOR ILLNESSES ASSOCIATED WITH EXPOSURE TO TOXIC SUBSTANCE DURING SERVICE ON ACTIVE DUTY IN THE ARMED FORCES

This bill would amend title 38, United States Code, to expand and facilitate compensation of veterans for illnesses associated with exposure to toxic substance during service on active duty in the Armed Forces. Although DAV has two resolutions on providing health care and benefits for veterans exposed to toxic substances while on active duty, we have not had sufficient time to review this bill thoroughly. We ask the Committee to allow DAV to submit supplemental comments on this legislation for the record, after we have had time to fully analyze this draft legislation.

DRAFT BILL, TO PROVIDE A LIMITED EXCEPTION TO THE 24-MONTH REQUIREMENT IN ORDER FOR VETERANS ENROLLED IN THE VA HEALTH CARE SYSTEM TO BE ELIGIBLE FOR PAYMENTS OR REIMBURSEMENT FOR NON-VA EMERGENCY TREATMENT

This bill proposes a limited exception to the 24-month requirement in order for veterans enrolled in the VA health care system to be eligible for payment or reimbursement for non-VA emergency treatment under title 38, United States Code, section 1725.

DAV Resolution No. 212 supports legislation to amend title 38, United States Code, to eliminate the provision that requires enrolled veterans to have received care from VA within the 24-month period prior to date of the emergency care. DAV believes a health care benefit package is incomplete without a provision for emergency care. Accordingly, the 24-month requirement under §1725 discriminates against otherwise healthy veterans who need not seek care at least once every 24 months, yet is required to make an otherwise unnecessary medical appointment in order to be eligible for payment or reimbursement for non-VA emergency treatment.

While DAV supports the concept of the legislation, which is to address the restrictive nature of the 24-month requirement included in §1725(b)(2)(B). We are concerned with the measures approach, which further fragments an already poorly constructed eligibility criterion, by providing relief to only “new veteran patients” with the “safety net” of non-VA emergency coverage.

Notably, “established patients” represent approximately 90 percent of VHA’s total outpatient appointments. Currently, the VHA defined “established patients” as those who have received care from a qualifying provider in a specific clinic in the previous 2 years; “new patients” represent all others.

VA examines wait times for completed appointments with the ultimate goal of delivering high quality service at the time wanted and needed by each veteran. In 2014, VA will measure wait times for primary care, specialty care, and mental health appointments for new and established patients. In 2013, VA updated the methodologies to measure wait times for “new” and “established patient” appointments to improve reliability and consistency. Appointments for “new patients” will use the create date, defined as when the appointment was made and automatically captured by the scheduling system. Appointments for “established patients” will use the desired date, defined as the agreed upon date determined together by provider and patient. Desired date is measured prospectively to better represent patient satisfaction. Therefore, no targets are set in 2013 and 2014 so that baseline performance can be established.

We also note the ill-defined legislative text “a waiting period imposed by the Department” pertaining to wait times associated with a newly enrolled veteran’s initial appointment at a VA medical facility is especially problematic. In determining “a waiting period,” this Committee is aware of continuing reliability issues of VA reported outpatient medical appointment wait times and the need for improving appointment scheduling oversight.⁷

⁷Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, Government Accountability Office, December 21, 2012. Washington, DC.

DRAFT BILL, TO REQUIRE ENTITIES THAT RECEIVE PER DIEM PAYMENTS THROUGH VA, FOR THE PROVISION OF SERVICES TO HOMELESS VETERANS, TO SUBMIT AN ANNUAL CERTIFICATION TO THE SECRETARY OF VETERANS AFFAIRS PROVING THAT THE BUILDING WHERE THE ENTITY PROVIDES HOUSING OR SERVICES IS IN COMPLIANCE WITH CODES RELEVANT TO THE OPERATIONS AND LEVEL OF CARE PROVIDED

This draft bill would amend title 38, United States Code, to require entities that receive per diem payments through VA, for the provision of services to homeless veterans, to submit an annual certification to the Secretary of Veterans Affairs proving that the building where the entity provides housing or services is in compliance with codes relevant to the operations and level of care provided.

The certification would include compliance with requirements outlined in the recently published version of the Life Safety Code or such other comparable fire and safety requirements as the Secretary may specify. Additionally, all licensing requirements regarding the condition of the structure and the operation of supportive housing or service center, including fire and safety requirements, must be provided.

DAV previously testified on a similar bill, H.R. 2065, introduced in the 113th Congress. While we did not have a National Resolution from our membership specifically covering the state of the housing provided to veterans or the safety of the facilities where homeless services are provided, we did not oppose favorable consideration of the legislation. However, we testified that H.R. 2065 may adversely impact Grant and Per Diem providers, which could leave many homeless veterans and their families without the services they need.

For entities that receive per diem payments during the year in which the legislation is enacted, the recipient must submit all certifications required to the Secretary no later than two years after the date of enactment, or additional per diem payments will be halted until certification is received. Both the Senate and House versions contain similar language; leaving the question unanswered as to what would become of the homeless veterans in these programs where their facilities fail to produce the mandated documentation?

While DAV agrees with the intent of the measure to provide safe shelters for our homeless veterans, we urge the Senate to work with the House to mitigate any detrimental effects this bill may have while meeting the needs of homeless veterans in a safe environment. Both bills contain sound components. They can be modified slightly to produce a comprehensive piece of legislation that takes into consideration the potential impact on homeless veterans that are serviced by grant recipients that fail to meet the criteria set forth in the legislation.

DRAFT BILL, TO RENAME THE BAY PINES VA HEALTHCARE SYSTEM

This bill would redesignate the Department of Veterans Affairs Healthcare System located at 10000 Bay Pines Boulevard in Bay Pines, Florida, as the "C.W. Bill Young Department of Veterans Affairs Medical Center."

This is a local issue. DAV does not have a national position on the matter.

DRAFT BILL, THE SERVICEMEMBER HOUSING PROTECTION ACT OF 2013

This bill would amend the Servicemembers Civil Relief Act to enhance the protections accorded to servicemembers and their spouses with respect to mortgages.

DAV does not have a resolution on this issue and takes no official position, but would not oppose enactment of such legislation.

DRAFT BILL, THE SUPPORT OF JOINT FEDERAL FACILITIES ACT OF 2013

This measure would provide VA the authority to enter into agreements with the Department of Health and Human Services (HHS) to share medical facilities with the goal of improving access to, and quality and cost effectiveness of, health care furnished by HHS. Funds transferred from the Department's accounts for medical care, and major and minor construction would be used in conjunction with HHS funds.

DAV has no resolution on sharing medical facilities with HHS; however, National Resolution No. 188 calls on Congress to carefully monitor any intended changes in VA infrastructure that could jeopardize VA's ability to meet veterans' needs for primary and specialized VA medical care and rehabilitative services.

Although DOD and VA have shared resources at some level since the 1980s, shared facilities with DOD have raised DAV's concerns over VA's ability under such sharing to ensure its resources are used in a cost-effective manner for the care and rehabilitation of ill and injured veterans. Through their reports, the Government Ac-

countability Office appears to validate our concerns in sharing facilities and resources.⁸

Like the original authorization provided to VA and DOD for a five-year demonstration project to integrate VA and DOD medical care into a first-of-its-kind Federal Health Care Center in North Chicago, Illinois, we ask the Committee to first consider a demonstration project for this new authority. Moreover, we ask the Committee consider additional provisions on VA and HHS to develop performance measures to show the extent of progress for effective management and strategic planning, and to assess the effectiveness and efficiencies in the provision of care and operations.

Mr. Chairman, this concludes my testimony and I would be happy to answer any questions from you or members of the Subcommittee.

Chairman SANDERS. Thank you very much, Mr. Atizado, and thank you for what the DAV is doing.

Colonel Norton.

**STATEMENT OF COLONEL ROBERT F. NORTON, USA (RET.),
DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY
OFFICERS ASSOCIATION OF AMERICA**

Colonel NORTON. Thank you, Mr. Chairman. It is an honor to be here with you today. Thank you Senator Burr, Senator Blumenthal. I represent some 380,000 members of the Military Officers Association of America.

Mr. Chairman, three of the bills on the agenda today would amend the Servicemembers Civil Relief Act or SCRA. Your bill, the SCRA Enhancement and Improvement Act makes a number of key improvements that support our active duty, National Guard, and Reserve members called to active Federal service.

I believe it is important to set this bill in a proper context. Since September 11, 2001, almost 900,000 members of the Guard and Reserve have been called up and over 300,000 have served on multiple tours of active duty. Reliance on our citizen soldiers has never been greater.

It is, in fact, our national policy that reservists can expect to be activated 1 year or every 5 years they are training part time at home. The legislation is also important, very important for active duty families.

The SCRA Enhancement and Improvement Act expands mortgage protections for service families required to move under military orders. It preserves civilian licenses and certifications that may expire during a combat zone deployment, and it prevents a servicemember from being denied or refused credit solely by reason of eligibility for the SCRA among other objectives in the bill.

Senator Jack Reed's Servicemember Housing Protection Act, S. 1593, complements your bill, Mr. Chairman. It includes a provision that extends SCRA mortgage foreclosure protection for 1 year to the surviving spouses of servicemen and women who made the ultimate sacrifice or who died in the line of duty.

⁸VA Health Care: Additional Efforts to Better Assess Joint Ventures Needed, GAO-08-399 (Washington, DC: Mar. 28, 2008); VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed, GAO-11-570 (Washington, DC: July 19, 2011); Electronic Health Records: DOD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs, GAO-11-265 (Washington, DC: Feb. 2, 2011); Costly Information Technology Delays Continue and Evaluation Plan Lacking, GAO-12-669 (Washington, DC: June 26, 2012); Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities, GAO 12-992 (Washington, DC: Sept. 28, 2012).

Another provision in the bill allows a military family who is renting off post housing to be able to break a residential lease without penalty in the event that on base housing opens up.

The bill would also trigger SCRA protections with a commanding officer's letter that would serve as a type of military order. Together these bills straighten the morale, well-being, and readiness of our Nation's military families. The Military Officers Association strongly supports these measures.

S. 1399, the Servicemember Student Loan Affordability Act, sponsored by Senator Durbin, is beneficial to young people with multiple student loans who agree to join our Armed Forces.

The bill allows them to consolidate student loan debt and gain the SCRA 6 percent interest rate cap. We believe this bill also supports recruitment of talented Americans with unique skills in demand by our Armed Forces.

Senator Tester's S. 1573 would allow the VA to make faster payments of DIC compensation to surviving spouses while formal paperwork is in the pipeline. We strongly support this bill.

S. 1262, the Veterans Conservation Corps, sponsored by Senator Bill Nelson, would establish a new program to support veterans transition to civilian life via temporary employment in conservation programs, law enforcement, firefighting, and disaster relief.

MOAA supports the bill in concept but we recommend that the legislation include an explicit authority to use GI Bill training benefits so that participants can gain a license or other credential at the conclusion of their training.

Turning briefly to VA health care legislation, we support your bill, Senator Burr, draft bill that would establish an outside independent study of the 21 VA Veterans Integrated Service Networks, or VISNs, to ensure that the system is working efficiently and effectively.

Mr. Chairman, we understand that your bill, the Veterans Health Care Eligibility and Expansion Enhancement Act is being parsed into two bills. MOAA strongly supports expanding enrollment opportunities for certain uninsured veterans consistent with the requirements of the Affordable Care Act.

Finally, MOAA strongly supports the provision in the bill that extends the period of time combat veterans can enroll in VA health care from 5 years to 10 years.

This concludes my statements. Mr. Chairman, thank you very much. I look forward to your questions.

[The prepared statement of Colonel Norton follows:]

PREPARED STATEMENT OF THE COLONEL ROBERT F. NORTON, USA (RET.), DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

Chairman Sanders, Ranking Member Burr and Distinguished Members of the Committee, On behalf of the over 380,000 members of The Military Officers Association of America (MOAA), I am pleased to present the Association's views on selected bills under consideration at today's hearing.

MOAA does not receive any grants or contracts from the Federal Government.

S. 1148, VETERANS BENEFITS CLAIMS FASTER FILING ACT (SEN. HEINRICH, D-NM).

S. 1148 would require the Department of Veterans Affairs (DVA) to compare the average claim processing time for various veterans' benefits depending on the method of filing, and to compare the grant of veterans' benefits among represented and

unrepresented veterans. The bill would make these reports available in each regional office and on the VA's Web site.

The data on benefits grants percentages would be reported based on whether the veteran was unrepresented, represented by a veteran service organization representative, or represented by another individual (usually an agent or attorney). The data on average processing time would compare processing time for two variables in claim filing methods: paper versus electronic filing, and fully developed claim filing versus non-fully developed claim filing.

MOAA is supportive of directing the Secretary to provide information about the effect of representation on grants of veterans' benefits. However, we are concerned that the report should compare like data points: many attorneys and agents screen cases and focus on representation of appeals, whereas veteran service organization representatives represent almost any claimant and provide complete claims service through the agency. We suggest that the Department of Veterans Affairs be directed to provide grant percentages for both original claims and appeals, and to provide an explanation of how the data is obtained.

MOAA is also supportive of directing the Secretary to analyze the results of VA's transformation to fully developed claims and electronic processing by reporting the average claim processing times. However, again, we are concerned that the report should compare like data as more veterans and representatives choose to use electronic filing methods and participate in the fully developed claims program.

We suggest that only the types of claims eligible for the fully developed claim program and electronic processing be included in this report, to make a direct comparison of the different filing methods. Also, we suggest that the form numbers (i.e., 21-526ez) or the breakdown on the VA's Monday Morning Workload Reports (i.e., by initial claim for compensation, less than seven issues) be used to separate results, so that claims for similar benefits can be compared. Certain benefits may lend themselves to the fully developed claim process and others may not.

We also suggest that the definition of "claim" include not only the "rating bundle" used to define VA's progress on the claims backlog and quality improvement measures, but also the "award adjustment" of a dependency claim. Although data on the average claim processing time of dependency claims may not be included in the VA's aspirational goals, it is very important in understanding that the way a claim is filed matters to the timeliness of a decision.

MOAA also would recommend the language of "durable power of attorney" be changed to "VA limited durable power of attorney," to reflect that a power of attorney to represent a veteran in matters before the Department of Veterans Affairs has no effect on health and medical care decisions and other legal matters beyond the authorization on VA Form 21-22 or 21-22(a).

MOAA is supportive of the intent of S. 1148, the Veterans Benefits Claims Faster Filing Act, and recommends: the bill be amended as outlined above; it reflect the nature of a VA power of attorney; and, enhance the data collected for the benefit of veterans' benefits claimants.

S. 1558, VETERANS OUTREACH ENHANCEMENT ACT OF 2013 (SEN. BEGICH, D-AK)

S. 1558 would require the DVA to extend outreach services to veterans via cooperative awareness programs with various Federal and state agencies. The bill provides resource incentives for state, local governments and veteran service organizations (VSOs) to assist veterans in utilizing DVA facilities and resources available to them. Other objectives of the legislation are to educate communities and State and local governments about employment and reemployment rights of veterans under the Uniformed Services Employment and Reemployment Rights Act (USERRA); provides technical assistance to veteran owned businesses; and, encourages non-profit groups, businesses and institutions of higher education to assist veterans. MOAA supports S. 1558.

S. 1211, (SEN. BOXER, D-CA).

S. 1211 would prohibit the use of the phrases "GI Bill" and "Post-9/11 GI Bill" to give a false impression of approval or endorsement by the Department of Veterans Affairs.

S. 1211 is consistent with recommendations that MOAA and other military and veterans service organizations made to the President on the issue of improving the oversight, outcomes reporting and consumer education of Department of Defense (DOD) and Department of Veterans Affairs (DVA) military and veterans educational benefit programs. Some of those recommendations are included in Executive Order 13607, Establishing Principles of Excellence for Educational Institutions Serving Servicemembers, Veterans, Spouses and Other Family Members (27 April 2012).

A specific MOAA recommendation reflected in Executive Order 13607 was to trademark the term “GI Bill.” Any entity that wishes to employ the term “GI Bill” must gain the DVA’s approval to use it. Subsequently, “GI Bill” has been trademarked and the DVA is responsible for enforcing its use. However, since trademarks are not permanent, MOAA believes that S. 1211 is needed to ensure the terms “GI Bill” and “Post-9/11 GI Bill,” signifying taxpayer-provided and government-administered educational programs for military members and benefits, are permanently protected.

We would, moreover, recommend consideration of including the phrases, “military friendly schools” and “veteran friendly schools” in the legislation, because these terms are bandied about by lead-generators and marketing operations to imply quasi-government endorsement, or unique services to student veterans that may not actually exist at self-identified “military friendly” or “veteran friendly” schools. We believe it’s very important for our government to provide reasonable consumer education protections for our returning warriors as they separate from military service and re-engage with their communities. MOAA endorses S. 1211.

S. 1262, THE VETERANS CONSERVATION CORPS ACT OF 2013 (SEN. BILL NELSON, D-FL).

S. 1262 would establish a veterans conservation corps to assist veterans in the transition from military to civilian life and to employ them in conservation, resource management and historic preservation projects on public lands; and temporary employment as law enforcement officers, firefighters, and disaster relief personnel.

MOAA appreciates Sen. Nelson’s leadership on this issue but is concerned over potential public perception and with veterans themselves that the bill is a make-work program and not a true path to long-term careers after military service.

S. 1262 does not appear to directly link the work and projects set out in the legislation with appropriate formal training, licensing or certification in the career areas described for GI Bill benefit purposes. A provision should be included in the bill that directs the Secretary of Veterans Affairs to establish approval of the training and work experience by State Approving Agencies leading to award of appropriate licensure or certification in specific fields in conjunction with GI Bill program payments under Chapter 30 or Chapter 33, 38 U.S. Code. Another option to consider, instead of creating a new program, is to increase job training, OJT and work-study reimbursement rates under the Post-9/11 GI Bill and the Montgomery GI Bill.

MOAA is supportive of the intent of S. 1262 and recommends amending the legislation to ensure veterans can receive a designated license, certification or OJT credential under the GI Bill at the conclusion of service in the veterans conservation corps. The legislation should lead to clear long-term career opportunities for veterans.

S. 1295, (SEN. BROWN, D-OH).

S. 1295 would require the VA to notify veterans (or their representatives) that they may use a veteran service organization representative (VSO) for the claims process when filing an electronic claim. The bill states that notice should include a list of names and web addresses for the VSOs. Currently, veterans receive a receipt for electronic claims filed through VONAPP Direct Connect in the eBenefits portal. There is a representative/agent/lawyer search in the eBenefits portal already that does not include Web sites but does list organization name, address and phone number. The VA Web site instructs veterans to use the VSO search before filing a claim but there is no such instruction in the eBenefits portal.

While MOAA supports the intent of the bill, the bill does not require the same notification for veterans filing a paper based claim. Veterans that file a fully developed paper claim through the mail using VA Form 526-EZ do not receive a notification that they may use a VSO until after the VA adjudicates their claim. MOAA recommends that the bill be expanded to cover veterans that file formal and informal claims by paper. MOAA supports the inclusion of web addresses for VSOs and other representatives to the representative search function in eBenefits.

MOAA is supportive of the intent of S. 1295, and recommends that the bill be amended to provide notification to veterans and other claimants that file claims by paper based methods.

S. 1361, WORLD WAR II MERCHANT MARINER SERVICE ACT (SEN. MURPHY, D-CT).

S. 1361 is a bi-partisan, no-cost bill that expands and clarifies the types of documentation for determining veterans status of certain “coastwise merchant seamen” (Merchant Mariners) during World War II, and for other purposes.

The GI Bill Improvement Act of 1977 (Public Law 95–202) provided that the Secretary of Defense could determine that service for the Armed Forces by organized

groups of civilians, or contractors, be considered 'active service' for benefits administered by the Veterans Administration.

In the case of World War II Merchant Marines, documenting their service has been difficult due to wartime security restrictions, destroyed ship logs and unavailable merchant mariner documentation known as a Z-card.

S. 1361 provides additional methods for documenting such service for consideration as active service by the Secretary of Veterans Affairs.

S. 1361 would authorize burial benefits; medals, ribbons and decorations; and status as a veteran (with no additional benefits) for Merchant Mariners who provide appropriate documentation under the bill. The bill also permits a primary next-of-kin of deceased WWII Merchant Mariners to submit evidence on their behalf of service to the United States.

MOAA supports the World War II Merchant Mariner Service Act, S. 1361.

S. 1399, THE SERVICEMEMBER STUDENT LOAN AFFORDABILITY ACT (SEN. DURBIN, D-IL)

S. 1399 would amend the Servicemembers Civil Relief Act (SCRA) to extend the interest rate limitation of six percent (6%) in two ways. A servicemember and the servicemember's spouse jointly who wish to refinance a student loan debt incurred before entering the service could do so at a rate not to exceed 6 percent. Under the bill, the 6% rate cap also could be applied to a student loan debt incurred by a servicemember and the servicemember's spouse jointly during military service.

Servicemembers enjoy a 6% rate cap on all pre-service loans under the SCRA. However, the law does not apply if a servicemember consolidates student loans that were taken out before their military service.

Loan consolidation is a practical, effective way to manage student loan debt. It's also the only way a borrower who has a Federal Family Education Loans (FFEL) or Perkins student loan can enroll in the Federal Public Service Loan Forgiveness (PSLF) program, a program that forgives student loan debt after 10 years of public service, including military service.

Unfortunately, servicemembers with student loans taken out before they joined the military who want their military service to count toward the 10 years of public service required under the loan forgiveness program must consolidate their student loans. But then they promptly lose the 6% loan rate cap that is afforded them by the SCRA.

This legislation could be particularly beneficial for supporting Armed Forces recruitment of highly qualified candidates with unique skills in demand by the military. MOAA supports S. 1399, the Servicemember Student Loan Affordability Act.

S. 1573 (SEN. TESTER, D-MT).

S. 1573 is a bi-partisan bill that would authorize the Department of Veterans Affairs (DVA) to immediately pay temporary Dependency and Indemnity Compensation (DIC) for up to six months to surviving spouses of fallen servicemembers and veterans who died of a service-related disability.

S. 1573 is common sense, no-cost legislation that enables quick payments from the DVA to eligible surviving spouses pending the receipt of formal paper work. Under Secretary of Veterans Benefits, the Honorable Allison Hickey, voiced the need for this legislation earlier this year in response at a Congressional hearing.

The legislation provides a financial bridge to support the essential needs of survivors who in many cases have endured hardship caring for a seriously disabled veteran. MOAA strongly supports S. 1573.

S. XXXX, SERVICEMEMBERS CIVIL RELIEF ACT (SCRA) ENHANCEMENT AND IMPROVEMENT ACT OF 2013 (SEN. SANDERS, I-VT).

The SCRA Enhancement and Improvement Act incorporates a number of needed technical fixes and enhanced protections for military women and men called to active Federal service.

The SCRA was originally enacted in World War II when hundreds of thousands of National Guard servicemembers and conscripts were being called to the colors. The need then and today was to create a financial and legal safety net primarily for our citizen-warriors and their families so that they could focus on their mission.

After September 11, 2001 Congress adopted numerous upgrades to the SCRA to protect the interests of active duty servicemembers and their families, as well as the National Guard and Reserves when activated.

Almost 900,000 reservists have been activated since Sept. 11, 2001 and over 300,000 have been called up for second, third or fourth tours of active duty. The Nation's reliance on the Guard and Reserve to support national security objectives at home and overseas has never been greater.

It is, in fact, our national policy to employ the Guard and Reserve in the operating force on a routine basis for the indefinite future. Under the DOD's "operational reserve" policy promulgated in January 2007 by then-Secretary Robert Gates, reservists are expected to be trained and ready for active duty service one year out of every five. Many reservists have actually been deployed as frequently as their active duty counterparts: three years' 'at home' and one year deployed. DOD leaders have indicated that the routine use of reserve capabilities will continue after the withdrawal from Afghanistan (2014) and the drawdown of the entire force as a result of sequestration and budget uncertainties.

In this context, it's hard to overstate the importance of the SCRA to morale, family well-being and military readiness.

The SCRA Enhancement and Improvement Act expands mortgage protections for service families required to move under "permanent change of station" (PCS) orders; preserves professional licenses that expire during a combat zone deployment; protects service families denied or refused credit solely because of the SCRA; raises financial penalty limits for willful violation of the statute; provides the Attorney General enforcement authority for the SCRA; and makes a number of other changes as summarized below.

TITLE I, SCRA ENHANCEMENTS

Section 101 would extend the coverage period for the protections under installment sales contracts to one year after a period of military service.

Section 102 would amend section 303(b) of the Servicemembers Civil Relief Act (SCRA) by changing "filed" to "pending" so that servicemembers may be eligible for stays of proceedings or adjustments of an obligation on real or personal property even if the action was filed before they entered service, or during a break in service.

Section 103 would prohibit the accrual of mortgage prepayment penalties incurred during a period of military service when discharging an obligation on a primary residence as the result of a receipt of permanent change of station orders.

Section 104 would provide servicemembers with relief from expiration of licenses or continuing education requirements during periods of eligibility for hostile fire or imminent danger pay and for an additional 180 days after such eligibility ends.

Section 105 would extend the protections preventing sale of personal and real property to collect unpaid taxes or assessments without a court order to real property owned by a business that is owned entirely by a servicemember or a servicemember and the servicemember's spouse.

Section 106 would prevent a servicemember from being denied or refused credit solely by reason of eligibility for the SCRA.

TITLE II, SCRA IMPROVEMENTS

Section 201 would clarify that the plaintiff in a default judgment action has an affirmative obligation to determine the defendant's military status and that the plaintiff must take steps accordingly, including but not limited to reviewing available Department of Defense records. It would also define the due diligence required of an attorney appointed by the court to represent a defendant who may be in military service.

Section 202 would prevent a waiver of a servicemember's SCRA rights or protections until after the occurrence of the event that gave rise to the rights or protections to be waived.

Section 203 clarifies that the Attorney General's authority to enforce the SCRA and an individual's right to file a private right of action existed before enactment of the Veterans' Benefits Act of 2010, which made this right explicit.

Section 204 would apply the protections related to mortgages to obligations on real or personal property for which a servicemember is personally liable as a guarantor or co-maker.

TITLE III, SCRA ENFORCEMENT

Section 301 would make arbitration clauses unenforceable unless all parties consent to arbitration after a dispute subject to the provisions of the SCRA arises.

Section 302 would allow the Attorney General to issue civil investigative demands in investigations under the SCRA. It does not include the authority to compel oral testimony or sworn answers to interrogatories.

Section 303 would increase the civil penalties for a first violation of SCRA from \$55,000 to \$110,000 and for second or subsequent violations from \$110,000 to \$220,000.

Informally, the Legal Assistance to Military Personnel (LAMP) Committee of the American Bar Association supports this legislation as do recognized reserve component legal experts.

MOAA strongly supports the Servicemembers Civil Relief Act (SCRA) Enhancement and Improvement Act of 2013.

S. XXXX, THE SERVICEMEMBER HOUSING PROTECTION ACT OF 2013
(SEN. JACK REED, D-RI)

The Servicemember Housing Protection Act would help military families in three ways: first, by permitting a servicemember to terminate a lease agreement under the SCRA in situations where government housing suddenly opens up. Several states already have similar laws, and this opportunity should be extended to servicemembers serving at any of our military bases.

Second, the legislation enables military families to gain SCRA protections with a letter from a commanding officer. There have been many cases in recent years where servicemembers are activated prior to the issuance of formal orders. The bill would apply the broader definition of military orders, allowing for commanding officer letters in all sections of the SCRA in which a servicemember is required to submit copies of military orders. This change will make it easier for servicemembers to more quickly get their affairs in order prior to deployment.

Third, legislation would extend the twelve-month window of foreclosure protections to surviving spouses. After suffering the unspeakable loss of a military husband or wife in service to the Nation, a surviving spouse should not have the additional burden of dealing with the potential of a mortgage foreclosure.

MOAA strongly supports the Servicemember Housing Protection Act of 2013 to expand protections under the SCRA for military families and surviving spouses.

S. XXXX, IMPROVING QUALITY OF CARE WITHIN THE DEPARTMENT OF VA ACT OF 2013
(SEN. BURR, R-NC)

The Improving Quality of Care Within the Department of VA Act of 2013 addresses two distinctly separate issues. The bill would require the DVA to ensure its policies regarding the reporting of infectious diseases be current and consistent with State laws. This makes good sense.

The second section of the bill requires that an outside independent assessment of the 21 VISNs and medical centers be conducted to study, evaluate and recommend organizational structures of medical centers; identify which key leadership positions in Medical Centers and VISNs should have succession plans and how to implement such plans.

The quest for standardization within the VA remains elusive. VISNs are considered the communication channel for centrally developed guidance to be sent out to the regions for local implementation. Directives from VA Central Office can take significant periods of time to be reviewed by local VA facilities and then may not be implemented as originally intended. We support any efforts to better streamline and standardize the VISN organizational structure.

MOAA supports the Improving Quality of Care within the Department of VA Act of 2013

S. XXXX VETERANS HEALTH CARE ELIGIBILITY EXPANSION AND
ENHANCEMENT ACT OF 2013 (SEN. SANDERS, I-VT)

Section 3 of The Veterans Health Care Eligibility Expansion and Enhancement Act of 2013 would expand access to VA health care for service-disabled, non-compensable veterans with no health insurance. Under the Affordable Care Act, VA health care is qualifying care for purposes of meeting the requirements of the law. This provision would enable this group of veterans to meet the ACA requirement via enrollment in the VA health system. MOAA supports the provision that expands access to VA care for certain uninsured veterans.

Section 4 of the bill would extend the period of time combat veterans can enroll in VA health care post-deployment from five years to ten years. MOAA strongly supports the provision that extends the VA health care enrollment period from 5 years to 10 years for combat veterans after returning from deployment.

Section 6 of the bill concerns VA Medicare Reimbursement.

Among Federal agencies, only the Indian Health Service is permitted to accept Medicare reimbursement in its facilities. Medicare eligible veterans are seen in the VA for service-connected conditions but often rely on outside medical care for routine services provided under Medicare, effectively splintering the continuity of health care.

Now is an opportune time to take a fresh look at allowing our enrolled, non-service-connected, Medicare eligible veterans to utilize the VA for all of their health care. More than 40% of enrolled veterans are eligible for Medicare.

In effect, rules excluding use of Medicare funds in VA facilities result in the government paying redundant costs for procedures and tests performed by Medicare providers and then, again, in VA facilities. That alone should be reason enough to consider using the VA as a Medicare provider.

If the VA can deliver a Medicare-sponsored benefit (for non-service-connected care) more efficiently than Medicare providers, while eliminating duplicative medical procedures, all stakeholders and especially veterans are likely to benefit.

Early in the last decade in separate Congressional sessions, the Senate and House passed legislation authorizing a test of VA Medicare Reimbursement to validate the theory that the government, taxpayers and veterans would benefit under VA Medicare reimbursement. Limited analytical studies also have been conducted on this issue and they suggest potentially favorable outcomes from VA Medicare Reimbursement.

MOAA continues to support the concept that Medicare-eligible veterans should be able to obtain their earned Medicare-sponsored services for non-service-connected care in VA health care facilities.

Since the Senate Finance Committee has primary jurisdiction over Medicare and Medicaid services, and due to earlier objections to Medicare “subvention” in VA facilities, we would respectfully suggest that the Committee consider sponsoring a formal test or pilot program of VA Medicare Reimbursement if outright enactment of the proposal is seen as infeasible at this time.

MOAA supports the establishment of a Medicare VA reimbursement program for non-service-connected care of enrolled Medicare-eligible veterans; we suggest that a formal pilot program may be the gateway to gain broad Congressional support for the concept.

S. XXXX, MENTAL HEALTH SUPPORT FOR VETERAN FAMILIES AND
CAREGIVERS ACT OF 2013 (SEN. SANDERS, I-VT)

S.XXXX would direct the VA to provide support for family members and caregivers of veterans with mental health disorders by establishing mental health education programs and group peer support programs. Both programs would be implemented via a contract with a non-profit entity with experience in mental health education and outreach. The language indicates that instructors for the group peer support meetings would be selected from family members or caregivers who had completed the initial training. It is not clear if these would be paid positions nor what alternative would be used if none of the participants wished to take on the responsibility of leading peer support groups.

MOAA is supportive of increasing support and education of caregivers who are coping everyday with the stresses associated with caring for our veterans with mental health (MH) concerns. Peer support is a proven concept within the veteran population and would provide our veteran families with a knowledgeable and safe place to learn, understand and share how best to help their veteran suffering with mental health problems. With the significant MH capabilities the VHA has developed over the past several years, it may make sense to consider utilizing internal assets to develop and implement these programs rather than contracting out to organizations who do not have the history and experience of veteran culture and healthcare.

MOAA supports the Veteran Families and Caregivers Act of 2013

S. XXXX ENHANCED DENTAL CARE FOR VETERANS ACT (SEN. SANDERS, I-VT)

This bill would create a three year pilot program providing dental care and treatment to enrolled veterans who are not eligible for dental care under current authorities. The pilot would be implemented in 16 VA locations, including rural areas and services would be consistent with the dental care provided to veterans with service-connected disabilities rated at 100% disabled. In addition to VA dental facilities, the services may be provided via contract by private providers in the community. The pilot program would also include dental health education be provided to the enrolled veteran via printed and electronic materials.

MOAA supports the Enhanced Dental Care for Veterans Act of 2013.

S. XXXX SURVIVORS OF MILITARY SEXUAL ASSAULT AND
DOMESTIC ABUSE ACT OF 2013 (SEN. SANDERS, I-VT).

This bill would authorize the DVA to provide care and treatment for victims of sexual assault or domestic violence who are members of the Armed Forces and requires the VA to screen veterans for sexual trauma and domestic abuse.

MOAA strongly supports this legislation but requests clarification of the language that describes the Armed Forces' eligible population. Sec 2. Line 15 notes that counseling and care may be provided to "members of the Armed Forces (including members of the National Guard and Reserves) on active duty * * *" We would request that language be included that clarifies that members of the Reserve Components who experienced sexual assault or domestic violence while on active duty remain eligible to receive treatment from the DVA after returning to drilling reserve status.

MOAA supports the Survivors of Military Sexual Assault and Domestic Abuse Act of 2013.

Chairman SANDERS. Thank you very much.
Mr. Weidman.

**STATEMENT OF RICK WEIDMAN, EXECUTIVE DIRECTOR FOR
POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS
OF AMERICA**

Mr. WEIDMAN. Thank you, Mr. Chairman and Ranking Member Burr, for the opportunity to appear here today.

I was asked last night by my distinguished colleague, Mr. Atizado, that he could not wait to try and see me comment on every single bill on the agenda today. So, I am not even going to try even though I have my fast New York accent when I need it.

I will comment and thank Senator Richard Blumenthal for moving forward on the Agent Orange Bill. It does a number of things, this bill. One is the most emotional issue by far all over this country is, among Vietnam veterans, is the issue of the grandchildren.

When we first stumbled into this was a town meeting in Louisville, Kentucky. Since that time, we have had such town meetings from North Carolina to Florida to Vermont, et cetera. Vermont actually was the first one we had but it did not highlight the grandchildren. This was way back in 1983 that the Chairman was involved in but it was all an Agent Orange.

We now have the biological plausibility and understand how patrilineal defects and often anomalies can not only be visited on the children but on the grandchildren. It is the field of epigenetics which frankly did not exist 20 years ago.

It is dioxin passes through the body. It does damage and alters the acids that serve as the on-off switches to the genes which shows up as anomalies. So, you have five-year-olds having heart attacks. You have three- and four-year-olds coming down with a rare cancers and particularly the cancers that are associated with exposure to Agent Orange.

The creation of a center for excellence on the already existing VA format where all medical centers can compete and it is based on what your organizational capability and how can you add to this. But it would also create an Office of Extramural Research.

We have had a real problem and the VA says that they do all the research that is necessary. In fact, they do not do any research on Gulf War Illness that is useful. They do not do any research on Agent Orange that is useful, with the exception of the National Vietnam Veterans Longitudinal Study which is due to be delivered to the VA next month. They only did that after Congress passed a law saying they had to and then we went through 12 years of beating them over the head.

With the assistance of folks on the Hill, they finally embarked on doing that study which will tell us a lot about mortality and morbidity of Vietnam veterans.

But what we need is something that is multi- generational that addresses the needs of Gulf War veterans, addresses the needs of Vietnam veterans, affects burn pits, and the Camp Lejeune. Any other toxic exposure which results in toxic wounds to our Nation's veterans needs to go through the same, is worthy of study and find out how do you treat these.

I am not going to get into the weeds on this now. In fact, the veterans organizations are meeting tomorrow afternoon to talk about it and see if we cannot come up with a united front back to Senator Blumenthal with any changes to keep everybody in the fold. But I think we are on the way to a really good bill at markup.

I would suggest also that while we are in favor of most of the bills that were on the agenda today, when it comes to the health care record, on this one VA skirts are clean because DOD has been blocking this process for twenty-some odd years.

What we have said and recommended to Secretary Hagel, who we have enormous respect and affection for, is adopt VistA and do it now and work together toward a common data warehouse both for DOD and VA; and you have not only operability but you do not have to translate anything. We need to develop that for VA anyway.

When we brought this to Assistant Secretary of Health, Assistant Secretary of Defense for Health, his comment was, "it is cheaper for DOD to go a different way." I said it is not cheaper for me as a taxpayer to go a different way. It is going to be a heck of a lot cheaper to the taxpayer to do the same system and make whatever improvements need to be made to VistA together, and those improvements should include military history.

I am 3 seconds over time, so I thank you for the opportunity again and welcome any questions, Mr. Chairman.

[The prepared statement of Mr. Weidman follows:]

PREPARED STATEMENT OF SUBMITTED BY RICHARD WEIDMAN, EXECUTIVE DIRECTOR
FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Chairman Sanders, Ranking Member Burr, and other members of this distinguished and important committee, Vietnam Veterans of America very much appreciates the opportunity to offer our comments concerning several bills affecting veterans that are up for your consideration. Please know that VVA appreciates the efforts of this Committee for the fine work you are doing on behalf of our Nation's veterans and their families.

S. XXXX, INTRODUCED BY SENATOR RICHARD BLUMENTHAL (CT), would establish in the Department of Veterans Affairs a national center for the diagnosis, treatment, and research of health conditions of the descendants of veterans exposed to toxic substances during service in the Armed Forces, and to provide certain services to those descendants.

VVA strongly supports this bill, which reflects positively as one of our foremost legislative goals. Not only would it help achieve a measure of justice for innocent victims of the use toxic substances in times of war, but it offers unlimited possibilities for scientific investigation.

Among the so-called invisible wounds of war are those brought home by troops that may not manifest for a decade or more. And most tragically, they may pass on genetically to the children of our Nation's warriors. And even to their children. We can only suspect, citing some studies mostly from abroad. But this country has not done enough research—has not wanted to fund enough research—into the potential intergenerational effects of exposure to toxic substances. Ask the VA how many

studies its hundreds of scientists are conducting in this realm. And the NIH. The CDC. Then ask yourselves, Why?

This legislation would also establish an Office of Extramural Research, to award grants to reputable scientists and epidemiologists to conduct research on wounds, illnesses, injuries, and other conditions suffered by individuals as a result of exposure to toxic substances while serving as members of the Armed Forces.

Perhaps most importantly, this legislation gives hope to the progeny of warriors who are suffering from health conditions determined by a board of advisors to have resulted from exposure to toxic substances. Those selected for care and treatment, at no cost to them and their caregivers, will be evaluated and treated at the designated center.

Of all the bills before you here today, this is perhaps most elemental to us. Because of our ongoing struggle with the unwanted legacy of Agent Orange. And because of our empathy for veterans of the first Gulf War with their still-undefined Gulf War illness, and for veterans and active duty troops of the fighting in Afghanistan and Iraq whose ingestion of fumes from burn pits will be their unwanted legacy. We ask that you give your full consideration to this bill.

S. 1547, INTRODUCED BY SENATOR RICHARD BURR (NC), THE VETERANS DIALYSIS PILOT PROGRAM REVIEW ACT OF 2013, would require the Secretary of Veterans Affairs to review the dialysis pilot program implemented by the VA and submit a report to Congress before expanding that program.

We understand that certain healthcare services are best performed by clinicians outside of the VA. Dialysis is one of these. It seems, however, that some folks in the VA are overeager to bring in-house dialysis outpatient clinics into the fold, and have the go-ahead and the dollars to start to do so.

The VA has identified the “first wave” of VA medical centers that will receive first year startup funding to construct internal dialysis capacity. Medical center directors have not been consulted and one VAMC director has stated that his hospital center has no interest in participating and does not wish to be in a position of having to fund out year costs associated with creating internal dialysis capacity.

The already selected sites are largely in urban areas where private sector dialysis capacity already exists. This means that veterans living in rural America remain unaffected. And consider: In May of this year, the VA awarded a national dialysis services contract to 23 private dialysis companies, both large and small, that provide full geographic coverage to veterans across the country as well as providing competitive rates in the range of Medicare. All VAMCs can utilize this contract as of the 1st of October; hence, there are regional dialysis contracts available to these medical centers and their community-based outpatient clinics, or CBOCS.

So * * * Is it necessary for the VA to rush helter-skelter into a questionable expenditure of capacity? Is this cost-effective? Or does it make more sense to keep this as a service to be contracted out? At the very least, any expansion of this program ought to be brought to a halt until the results of the pilot program are compiled by the Secretary and reported to Congress.

S. 1558, INTRODUCED BY SENATOR MARK BEGICH (AK), THE VETERANS OUTREACH ENHANCEMENT ACT OF 2013, would require the Secretary of Veterans Affairs to carry out a program of outreach for veterans.

Under Secretary Shinseki’s leadership, the VA is continuing to pursue the most effective—if not necessarily coordinated—outreach program since the end of the Second World War. While the Secretary and others deserve credit for what they have done and are doing, there is still much that needs to be done to educate veterans and their families regarding the benefits and services they have earned in service to the Nation.

With modest funding over a five-year period, this bill will help fill a gap in rural America. We would suggest, however, that some of the effort go to placing simple messages about key veterans benefits on billboards in well-traveled areas. With this modest caveat, VVA supports this measure.

S. 1296, INTRODUCED BY SENATOR BILL NELSON (FL), THE SERVICEMEMBER’S ELECTRONIC HEALTH RECORDS ACT OF 2013, would amend the Wounded Warrior Act to establish a specific timeline for the Secretaries of Defense and Veterans Affairs to achieve interoperable electronic health records.

Years ago, when the VA and DOD began this effort to achieve interoperable electronic health records, both departments—their key leaders and IT personnel—should have sat down together with members of both the Senate and House Veterans’ Affairs Committees and discussed the projected timeline for completing this project—and the incumbent problems likely to present along the way, e.g., what the costs would amount to; how DOD would get its three services into line.

Finally, Senator Nelson is attempting to do all this with this bill, which would achieve

(1) the creation of a health data authoritative source by the Department of Defense and Department of Veterans Affairs that can be accessed by multiple providers and standardizes the input of new medical information is achieved not later than 180 days after the date of the enactment of this subsection;

(2) the ability of patients of both the Department of Defense and the Department of Veterans Affairs to download the medical records of the patient (commonly referred to as the 'Blue Button Initiative') is achieved not later than 180 days after the date of the enactment of this subsection;

(3) the full interoperability of personal health care information between the Departments is achieved not later than one year after the date of the enactment of this subsection;

(4) the acceleration of the exchange of real-time data between the Departments is achieved not later than one year after the date of the enactment of this subsection;

(5) the upgrade of the graphical user interface to display a joint common graphical user interface is achieved not later than one year after the date of the enactment of this subsection; and

(6) each current member of the Armed Forces and the dependent of such a member may elect to receive an electronic copy of the health care record of the individual beginning not later than June 30, 2015."

This is indeed admirable, and much needed, but perhaps not realistic on two counts: First, considering the snail's pace of progress seemingly made by the IT gurus of the two departments, the timelines stipulated in this legislation is perhaps a bit unrealistic. And second, without penalties and real enforcement, the due dates may as well be written in sand.

S. 1295, INTRODUCED BY SENATOR SHERROD BROWN (OH), is a bill that would require the VA Secretary to provide veterans with notice when they electronically file claims for benefits that relevant services may be available from veterans service organizations, and notify each claimant or claimant representative that application services may be available from veterans service organizations and provide such claimant or representative with a list of such VSOs.

Far too many veterans submit claims for disability compensation themselves. The assistance they receive from a VA employee amounts, for the most part, to legal malfeasance if not malpractice. At VVA, we advise any veteran who calls about a claim to get representation from a veteran's service representative, from a VSO or from the county in which s/he resides. Because they have been certified by the VA and they know (at least they ought to know) how to cross the t's and dot the i's. Hence, VVA strongly favors enactment of this measure.

S. 1148, INTRODUCED BY SENATOR MARTIN HEINRICH (NM), THE VETERANS BENEFITS CLAIMS FASTER FILING ACT, would direct the Secretary of Veterans Affairs to post in a conspicuous place in each VA Regional Office and claims intake facility and on the VA Web site information on: (1) the average processing time for fully developed and not fully developed VA benefits claims submitted in specified forms, and (2) the percentage of such claims filed by specified methods for which benefits are awarded. It also requires the Secretary to notify each person submitting a claim for a VA benefit of such information and of the person's eligibility to receive up to an extra year of benefit payments if the person files a claim that is fully developed, and requires the notice information to be updated at least quarterly.

Veterans of every generation can and do make good and rational decisions when they have timely and accurate data to help inform their decisionmaking. The requirements of this bill should have been realized years before now in order for the VA to be in conformance with the President's Executive Order(s) regarding open government and accountability. In any case, VVA welcomes this initiative and supports enactment of S. 1148.

S. 1211, INTRODUCED BY SENATOR BARBARA BOXER (CA), would prohibit the use of the phrases "GI Bill" and "Post-9/11 GI Bill" to give a false impression of approval or endorsement by the Department of Veterans Affairs.

There are many legitimate not-for-profit and for-profit institutions of higher learning that are committed helping their students acquire a decent education and/or training that will be immediately marketable. However, there are some predatory institutions that have unscrupulously charged high tuitions from veterans, but delivered little of value in return. While many of these "colleges" deceitfully attempt to appear to be accredited, they are in fact not accredited by a reputable accreditation body. Therefore the "degrees" granted by these outfits are useless to the vet-

eran, as their phony degrees are not recognized by employers, legitimate colleges and graduate school, or by state licensing bodies.

In many instances these same predatory institutions have used the phrases GI Bill and Post-9/11 GI Bill in misleading advertisements to try and make it appear as if they are sanctioned by the VA. The VA has taken the first step, by registering the term “GI Bill.” And enactment of this legislation should be helpful in limiting further damage by these predators to our returning warriors.

Some would call these predators “war profiteers” in the ugliest sense of that phrase. Others would label the behavior of these entities and all of those who reap huge profits from them as “stolen valor” in that they are robbing these post-9/11 veterans of the ability to acquire a useful degree and marketable education and training. The only thing wrong with this bill is that it does not go far enough. VVA strongly favors early passage of this measure.

S. 1399, INTRODUCED BY SENATOR RICHARD DURBIN (IL), WOULD AMEND THE SERVICEMEMBERS CIVIL RELIEF ACT to extend the interest rate limitation on debt entered into during military service to debt incurred during military service to consolidate or refinance student loans incurred before military service.

This sensible bill would protect servicemembers by enabling them to consolidate or refinancing earlier student loans and current loans at a maximum 6% rate. This is a good deal for our men and women in uniform, and should be passed by Congress with all due speed.

S. 1411, INTRODUCED BY SENATOR AL FRANKEN (MN), THE RURAL VETERANS HEALTH CARE IMPROVEMENT ACT OF 2013, would specify requirements for the next update of the current strategic plan for the Office of Rural Health of the Department of Veterans Affairs for improving access to, and the quality of, health care services for veterans in rural areas.

Because we have found that most “strategic plans” of the VA are mostly a waste of trees, we in good faith cannot support S. 1411, even though it embraces some very good ideas, e.g., the better use of telemedicine.

It seems to us that the VA knows what it needs to do to improve healthcare services to veterans living in rural and remote areas of America. What it doesn’t need is yet another “plan” that is dated before it is printed to tell it what needs to be done.

S. 1155, INTRODUCED BY SENATOR JON TESTER (MT), THE RURAL VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT, would amend appropriations authorities for veterans’ benefits to provide advanced appropriations for information technology relating to medical services, support, compliance, and facilities of the Veterans Health Administration (VHA). It would require the Secretary to provide mental health services, including outpatient care, to the immediate families of certain veterans returning from Operation Enduring Freedom or Operation Iraqi Freedom. It would also require the Secretary to report to Congress regarding telemedicine services for veterans, including updates on VA teleconsultation and telemedicine initiatives, training, and partnerships with primary care providers.

The VHA has made significant strides in the use of telehealth/telemedicine, most usefully in rural and remote areas. While we hope, and anticipate, that advance appropriations for all of the VA’s discretionary appropriations will be enacted during this session of Congress, we do hope as well that Congress will see the wisdom of expanding and improving the use of telemedicine services for veterans, and so we certainly support passage of S. 1155.

S. 1262, INTRODUCED BY SENATOR BILL NELSON (FL), THE VETERANS CONSERVATION CORPS ACT OF 2013. This bill would:

(a) ESTABLISHMENT—The Secretary of Veterans Affairs shall, in cooperation with the Attorney General, the Secretary of Agriculture, the Secretary of Commerce, the Secretary of Homeland Security, the Secretary of the Interior, and the Chief of Engineers, establish a veterans conservation corps to assist veterans in the transition from service in the Armed Forces to civilian life and to employ veterans—

(1) in conservation, resource management, and historic preservation projects on public lands and maintenance and improvement projects for cemeteries under the jurisdiction of the National Cemetery Administration; and

(2) as firefighters, law enforcement officers, and disaster relief personnel.

(b) CONSERVATION, RESOURCE MANAGEMENT, HISTORIC PRESERVATION, AND CEMETERY MAINTENANCE AND IMPROVEMENT PROJECTS—

(1) In general—As part of the veteran’s conservation corps, the Secretary of Veterans Affairs, the Secretary of Agriculture, the Secretary of Commerce, the Secretary of the Interior, and the Chief of Engineers shall—

- (A) employ veterans to carry out projects described in subsection (a)(1); or
- (B) award grants to, or enter into contracts with, State governments, local governments, or nongovernmental entities to employ veterans to carry out projects described in subsection (a)(1).

The veterans who really need help with finding jobs are those 18–24-year-olds and 25–29-year-olds, most of whom are with the National Guard or Reserves, who have few marketable skills. (Veterans unemployment rates are actually well under that of most other Americans.) Such a program, the cost of a few days' operation in Afghanistan, is certainly worth the price—and the futures of potentially thousands of young men and women.

S. 1361, INTRODUCED BY SENATOR CHRISTOPHER S. MURPHY (CT), WORLD WAR II MERCHANT MARINER SERVICE ACT, would direct the Secretary of Homeland Security to accept additional documentation for verifying that an individual performed honorable service as a coastwise merchant seaman during the period beginning on December 7, 1941, and ending on December 31, 1946, for purposes of eligibility for veterans' benefits under the GI Bill Improvement Act of 1977.

The situation of those American citizens who served in these potentially dangerous positions during World War II should have been corrected many years ago. This historic wrong needs to be formally righted. VVA has favored such legislation conferring full veteran status on these individuals for almost thirty years, and now urges swift passage of this measure before all of them are dead and gone.

S. 875, INTRODUCED BY SENATOR CASEY (PA), THE DEPARTMENT OF VETERANS AFFAIRS DISEASE REPORTING AND OVERSIGHT ACT OF 2013, would requires the director of a Veterans Integrated Service Network, within 24 hours after confirming the presence of a notifiable infectious disease at a Department of Veterans Affairs (VA) facility under that director's jurisdiction, to notify: (1) the Central Office of the VA; (2) the Director of the Centers for Disease Control and Prevention; (3) the state and county in which the facility is located; (4) each individual at the facility who has contracted the disease or is at risk of doing so, as well as the individual's next of kin, the individual's primary health care provider, and the county in which the individual resides; and (5) each VA employee of such facility. Requires such director to comply with any earlier notification required by the state concerned.

Requires such director to: (1) confirm receipt of such notification, (2) develop and implement an action plan to manage and control the potential spread of the disease, and (3) keep records of any such notifications for at least 10 years. Requires an annual report from the VA Inspector General to Congress on directors' compliance with the requirements of this Act. Provides for Inspector General enforcement and appropriate director disciplinary action with respect to such requirements.

Directs the Under Secretary for Health of the Veterans Health Administration (VHA) to issue a directive to the VHA's pathology team, infection prevention team, facilities management team, and other appropriate VHA groups on the actions to be taken when a notifiable infectious disease is discovered in a VHA facility.

Inasmuch as almost everything in this bill is what common sense would dictate in the event of an outbreak of a notifiable disease at a VA medical facility, it would seem that this legislation would not ever be needed. However, in the wake of the "Legionella" outbreak at the VA Medical Center in Pittsburgh, Pennsylvania, and the subsequent lack of proper and sensible steps being taken to notify either the community or the VA hierarchy in a timely manner, this would seem to be a prudent step for Congress to take. Although the situation was probably not as badly handled as some outside of VA have portrayed it, the situation was still not handled correctly.

VVA favors enactment of S. 875.

S. 1165, INTRODUCED BY SENATOR JON TESTER (MT), THE ACCESS TO APPROPRIATE IMMUNIZATIONS FOR VETERANS ACT OF 2013, includes within authorized preventive health services available to veterans through the Department of Veterans Affairs immunizations against infectious diseases, including each immunization on the recommended adult immunization schedule established by the Advisory Committee on Immunization Practices.

VVA strongly favors any additional mechanisms that promote better accountability in the delivery of VA services, including immunizations, and therefore endorses enactment of S. 1165.

S. 1281, INTRODUCED BY SENATOR RICHARD BLUMENTHAL, (CT), VETERANS AND SERVICEMEMBERS EMPLOYMENT RIGHTS AND HOUSING ACT OF 2013, prohibits employment practices that discriminate based on an individual's military service and

amends the Fair Housing Act and the Civil Rights Act of 1968 to prohibit housing discrimination against members of the uniformed services.

Declares that it shall be an unlawful employment practice for an employer to fail to hire, to discharge, or to otherwise discriminate against individuals because of their military service. Prohibits employers, employment agencies, labor organizations, and job training programs from engaging in specified practices that adversely affect an applicant or employee because of such service.

Amends the Fair Housing Act to prohibit housing discrimination against a member of the uniformed services with respect to: (1) the sale or rental of housing, (2) residential real estate-related transactions, and (3) the provision of brokerage services.

Amends the Civil Rights Act of 1968 to impose a fine, imprisonment, or both on persons who violate prohibitions on housing discrimination under such Act against members of the uniformed services.

VVA favors the provisions in this act. However, what is really needed is enforcement of already existing statutes that bar such behavior. Unless there is an effective means for timely and effective redress for veterans who encounter such discrimination in employment or housing, then all of the various laws will not matter in the lives of veterans who become subject to such discrimination. Certainly the Office of Federal Contract Compliance Programs and the Vietnam Era Veteran Readjustment Act (VEVRA) is a classic example of good intentions gone awry inasmuch as they have assisted less than 30 veterans in the last 40 years.

S. 1556, INTRODUCED BY SENATOR SHERROD BROWN (OH), would modify authorities relating to the collective bargaining of certain employees in the Veterans Health Administration.

Should a psychiatrist who works for the VA have the same rights concerning "grieving" his or her schedule as a psychologist? Should a registered nurse have the same rights as a licensed practical nurse? Seems to us they should; according to the VA, they don't. Nor do physicians, dentists, physician assistants, podiatrists, optometrists, chiropractors, and certain dental auxiliaries. This personnel policy seems schizoid, and without merit—and yet another reason why the VBA has difficulty retaining top-shelf doctors and dentists and registered nurses.

VVA supports fully the passage of S. 1556 because it strikes out against indefensible bureaucratic curmudgeonliness, and for employee justice.

S. 1559, INTRODUCED BY SENATOR RICHARD DURBIN (IL), THE BENEFITS FAIRNESS FOR FILIPINO VETERANS ACT OF 2013, would modify the method of determining whether Filipino veterans are United States residents for purposes of eligibility for receipt of the full-dollar rate of compensation under the laws administered by the Secretary of Veterans Affairs.

Is he or isn't he? Does he reside in the United States, thereby earning him top-dollar compensation for his wartime service, or does he really reside in the Philippines? Enactment of this legislation, one would hope, would help clarify the situations of a number of Filipinos who served under the U.S. flag during the Second World War, and VVA supports its enactment.

S. XXXX, INTRODUCED BY SENATOR BERNARD SANDERS (VT), would update the Service-Disabled Insurance program to base premium rates on the Commissioners 2001 Standard Ordinary Mortality table instead of the Commissioners 1941 Standard Ordinary Table of Mortality.

Gee, progress! VVA of course supports this effort by the Chairman to bring a modicum of rationality to this program.

S. XXXX, INTRODUCED BY SENATOR BERNARD SANDERS (VT), would provide replacement automobiles for certain disabled veterans and members of the Armed Forces.

A measure of this ilk has been needed for some time, especially in those areas of the Nation where public transportation is spotty or non-existent. Hence, VVA supports this bill.

S. XXXX, INTRODUCED BY SENATOR BERNARD SANDERS (VT), THE VETERANS HEALTH CARE ELIGIBILITY EXPANSION AND ENHANCEMENT ACT OF 2013.

This bill would open the VA healthcare system to all eligible veterans, meaning all veterans who meet certain criteria and who have received other than a dishonorable discharge. As long as a mechanism to gradually admit veterans is written into regulation so as not to overwhelm the system, VVA wholeheartedly supports this measure. Nor do we believe that the healthcare system will be overloaded inasmuch as most veterans who are able to afford private insurance under ACA or through

the entity for which they work will likely prefer to go to their own medical and dental professionals.

S. XXXX, INTRODUCED BY SENATOR BERNARD SANDERS (VT), THE ENHANCED DENTAL CARE FOR VETERANS ACT OF 2013.

Several studies have shown that poor dental health contributes to and in fact leads to deterioration of the overall physical and mental health. This being so, the case is compelling to add dental care to the package of benefits to patients at VA healthcare facilities who are not 100 percent service-connected disabled. This is hardly a luxury; rather, it is a vital element of an overall wellness program that the VA claims is a goal for all of its patients. We believe that an econometric study would show that it costs less to provide reasonable dental care than it does to treat the ravages that poor teeth wreak on the health of veterans, particularly low-income veterans.

The VHA has made headway in this arena, offering all of its patients the opportunity to purchase dental insurance at seemingly reasonable rates. This, however, will not help the poorest veterans who have neglected their dental health for too long.

VVA fully support enactment of this legislation.

S. XXXX, INTRODUCED BY SENATOR BERNARD SANDERS (VT), THE MENTAL HEALTH SUPPORT FOR VETERAN FAMILIES AND CAREGIVERS ACT OF 2013.

It seems to us that in order to help a veteran who has Post-traumatic Stress Disorder or Traumatic Brain Injury, especially chronic PTSD or TBI, family members and caregivers need support and assistance if efforts of the VA are to have any chance of success at even mitigating these issues and helping the veteran achieve a decent quality of living. Assuming that this bill will help achieve some degree of success in this area, VVA supports its enactment as a step in the right direction.

S. XXXX, INTRODUCED BY SENATOR BERNARD SANDERS (VT), THE SURVIVORS OF MILITARY SEXUAL ASSAULT AND DOMESTIC ABUSE ACT OF 2013, would provide counseling and treatment for sexual trauma to members of the Armed Forces; require the Secretary to screen veterans for domestic abuse; and require the Secretary to submit reports on Military Sexual Trauma (MST) and domestic abuse.

Considering the somewhat belated attention being paid to MST, this bill takes a rather proactive approach to assisting veterans who have been victimized by abuse. In the arena of domestic abuse, however, the bill may be going a bit too far for the veterans' own good by "develop[ing] and implement[ing] a screening mechanism to be used when a veteran seeks healthcare services * * * to detect if the veteran has been a victim of domestic abuse for purposes of improving the treatment of the veterans and assessing the prevalence of domestic abuse in the veteran population."

Either way, VVA endorses enactment of this legislation.

S. XXXX, INTRODUCED BY SENATOR JON TESTER (MT), would provide for the payment of temporary compensation to a surviving spouse of a veteran upon the death of the veteran.

How can anyone not be in favor of such legislation? We have heard of far too many instances in which a veteran dies, leaving his spouse just this side of destitute. To provide the VA with the means to pay temporary compensation to assist her, or him, in this difficult time is more than fitting. It is simply the right thing to do.

VVA supports this measure.

Again, on behalf of our membership, we thank you for the opportunity to present our testimony before this Committee, and we thank all of you for the work you are doing on behalf of our Nation's veterans and our families.

Chairman SANDERS. Thank you very much, Mr. Weidman.

Let me just start off and ask each of you very briefly. All of your organizations have people who access the VA health care system. What are you hearing? Is it a good system? Mr. Atizado. I am murdering your name here and I apologize for that.

Mr. ATIZADO. Adrian is fine.

Chairman SANDERS. Adrian, all right. That I can handle.

Mr. ATIZADO. I believe so, Mr. Chairman, generally. As an advocacy organization the things we hear about are the same things

that a lot of Members on this Committee and the staff probably hear as well are just complaints.

But, you know, the type of complaints that we get really are more about implementing policy and not the quality of care. To that end, those that we do have the opportunity to speak with that are patients in our organization love the VA. They will defend it and they are very strong advocates, vocal advocates, also very vocal critics when it needs to be. I think that is the overall perspective our members have about VA health care.

Chairman SANDERS. Colonel Norton.

Colonel NORTON. Thank you, Mr. Chairman.

You know the VA that Rick and I experienced coming back from Vietnam 40 plus years ago compared with today is light years different. I mean, it is by many different measures, studies, et cetera, has a markable record of safety and quality.

Sure, more needs to be done. I would say that information outreach and access is an issue especially for veterans that do not understand or know that they may be eligible to enroll in VA health care.

Chairman SANDERS. Mr. Weidman.

Mr. WEIDMAN. Overall it is an excellent system. On special needs of vets, particularly neuropsychiatric, spinal cord injury, amputations and prostheses—they are ahead of most American medicine.

So, we think it is an excellent system. We strongly favor your bills opening it up and including dental care in that.

Chairman SANDERS. Well, let me pick up on that, Mr. Weidman.

Do you bump into Vietnam vets who would like to access VA health care but are ineligible to do so?

Mr. WEIDMAN. I do, sir.

Chairman SANDERS. And do you think opening up the system would give them the opportunity to access good quality health care?

Mr. WEIDMAN. I think it would if they know about it. I cannot tell you the number of people who do not—even going to the VA Web site, if you look up diabetes in the patient library you want to know more about diabetes, it does not mention a darn thing about Agent Orange.

Chairman SANDERS. Well, you have raised an issue dear to my own heart. We have had at least one hearing on that issue already and we are going to do more. I think if you go to the Web site, it is a better Web site today than it was a year ago.

Mr. WEIDMAN. Absolutely.

Chairman SANDERS. You are seeing ads on television and on the radio which are pretty good. So, I think these guys are trying to get their act together. Not everybody, you know, not every veteran wants to use the VA and that is fine. But I think our job is to make sure that every veteran in America knows what he or she is entitled to so if they do want to use the system they can come in.

So, I agree with you that outreach remains an issue and it is an issue that this Committee is going to continue to work on.

Adrian, what do you think? Are there folks out there who would like to access VA but are ineligible and do not know about the system?

Mr. ATIZADO. I am pretty sure there are, Mr. Chairman, yes.

Chairman SANDERS. So, one of the things that we want to do is to expand VA eligibility and bring more veterans into what we consider to be a strong and cost-effective system.

Any of you want to comment on dental care or am I the only person in the world obsessed by this issue?

Mr. ATIZADO. I will gladly do it, and I will echo my comments with Mr. Weidman. Dental care is a longstanding issue for DAV. As you mentioned and was mentioned by other folks, including Dr. Jessie behind me, it is a critical part of health care.

For whatever reason, there are parts of VA's medical benefit package that has not caught up with what we believe health care to be today, whether it is certain parts of long-term care and in this particular case dental care. So, we are very supportive of that bill. We would like to see it get into the fold of the medical benefit package, yes.

Chairman SANDERS. Colonel.

Colonel NORTON. Thank you, Mr. Chairman.

The reality is that the view that dental health and physical health are distinct and different aspects of treating the human person is old thinking. It is obsolete.

The reality is that you can have severe dental health issues that affect your overall health. I would add that we have had the experience early in the last decade when tens of thousands of members of the Reserves were called up that became compounded when they came back and became veterans.

Many of them had teeth pulled. They did not get proper care from DOD. They really just had to get them deployed into the combat zone and so they did not provide proper dental health care.

Now, that is being visited really on the VA system now that many of them are applying for health care access there.

Chairman SANDERS. Mr. Weidman.

Mr. WEIDMAN. Dental care is, in fact, part of health care. We met with the VA dentists numerous times. There have been many studies that we have reviewed about it being key to maintenance of overall wellness.

The people who you do not take care of who do not have the ability themselves to pay for dental care are going to end up at VA because they are going to be indigent and so sick that they get in. Why not see them before they get that sick?

I also want to mention something. Years ago when I was chairman of the board of PAVE in Vermont, we had a smart counselor in St. Johnsbury, and he had a client who stayed drunk all the time, and he could not get him to go to the hospital, could not do anything. His wife had thrown him out, et cetera.

He figured out that the key was the guy had no teeth. So, he said I do not know what to do. CEDA will not pay for it. So, I went to a friend who was a classmate at Colgate who was a dentist in Stowe and he had been instrumental in starting the ToothFairy Program.

He said, do you have somebody in St. J who will do it if we buy the materials. The board of PAVE, all Vietnam vets, chipped in to buy the materials. We got the guy a new set of choppers, got him down to White River Junction to Matt Freedman and turned him

around on the PTSD and the alcohol. We got him a job, and his wife took him back and that was his story.

The barrier to employment could be anything but in this case it was his health and it was his teeth. That was the key to his overall well-being.

Chairman SANDERS. Excellent point.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Let me start by thanking all of your organizations for their support for the Camp Lejeune water contamination issue.

Rick, as you know, it is a very long process to go through. The whole study of water toxicity—we have made more progress in the last 2 years than we have in the past 20 years, and I hope that there is a blueprint that we create through that for other toxic exposures that may exist.

Let me also ditto what you said about the electronic medical records being a DOD problem and not a VA problem. As one person's opinion who has been in the debate on this side of the dais, I have always seen a willingness on the part of VA and expertise on the part of the VA and I have seen nothing but reluctance and pull back on the part of DOD.

And I say that to my colleagues that are on the Armed Services Committee. I do not think it is a lack of willingness on the VA side. It is clearly a lack of willingness on the part of the DOD, and I hope we can close that gap.

If I could pray for any IT explosion at the VA, it would be for a new appointment program that would actually walk somebody through to where a veteran could actually access all their doctors in one visit versus the multiple visits that it takes today.

I think that is a difficult thing to explain that it cannot be done and it is not because of the lack of money. We have spent a tremendous amount of money only to have a failure again.

Colonel Norton, in your testimony regarding my bill, the Improving Quality of Care Within the Department of Veterans Affairs Act of 2013, you stated this, "Directives from VA central office can take significant periods of time to be reviewed by local facilities and then not implemented as originally intended."

What do you believe are those bottlenecks?

Colonel NORTON. I think this gets back to what Adrian said earlier, that there is a culture of individuality out there in the VISNs that even though the central office might issue a particular directive or policy, the way that it is implemented turns into a completely local affair. It has to do with the leadership there and the responsiveness of that local system to VA central.

It is an elaborate problem and I think your bill is needed in order to address a more outside systematic look at an efficient way to run the railroad, if you will.

Senator BURR. Our hope is to structurally put some accountability into the system.

Rick, in your testimony regarding my dialysis bill, S. 1547, you stated that dialysis is one of those services best performed by clinicians outside of VA. However, as you stated in your testimony, some folks in the VA are overeager to bring dialysis outpatient clinics into the fold.

Why, in your opinion, is VA overeager?

Mr. WEIDMAN. It is not just on this issue. The contracting out makes sense where veterans have to travel great distances. Even in some States—we do not usually think of North Carolina as rural like parts of the rest of the country.

Senator BURR. Only 80 percent of it is.

Mr. WEIDMAN. Right. But for those in the rural areas—it is really rural when you get out west. The point is that in those areas to contract out makes a great deal of sense for all the reasons that Senator Johanns talked about earlier, where there are quality facilities out there you can contract with.

But to contract out where there is dialysis already existing in urban areas makes no sense to us unless you can show it is amazingly more cost-effective for VA to develop its own dialysis unit. The capital costs in developing a dialysis unit and keeping it staffed properly and up to date, I think you could do much more easily outside.

Senator BURR. Well, let me just say I have challenged Dr. Jesse to present the sales pitch to me of why this should be done internally.

I will take my 53 seconds that I have got to editorialize a little bit. In addition to the wishes of the Chair to expand access to the VA, we cannot lose focus on the fact that over the next decade we will have probably 500,000 individuals who separate from the military and who are eligible in some way, shape, or form for VA.

In my State of North Carolina, we are not in a position today to physically handle what we currently have just from military retirees who are moving to North Carolina and VA eligible. This is not a secret. The VA recognizes that too.

If we begin construction today, I am not sure that we could ever meet the needs of all who will migrate there as retirees and those that will separate from the military and name North Carolina has home.

Given the fact that we cannot do that and there are going to be continuing pressures on the need for additional facilities, personally, and I say this, Dr. Jesse, and I hope you hear it, I am not sure why we would waste the capital to create something that seems to work fairly well on a contract basis because we are going to need that capital to stand up delivery points for the delivery of care where there is no expertise or availability outside of VA.

Chairman Sanders and I have talked about ways that we might be able to leverage the federally qualified community health centers in a way that we can actually put a VA presence closer to where veterans live.

You know, if you have to put a VA sign over a door and put a new door in or have dual services that are operated by the x-ray machine and copy machine and a nurse, even if you have to have two separate physicians, our ability to do that because our objective here—which I do not think it is at odds with the VA's objective—is to keep veterans healthy, to keep them out of our hospitals, to do as much things in outpatient facilities as we can.

It means the expansion of things like HCCs with ambulatory outpatient surgery centers. It means some degree of partnership with community health care centers for any overnight observation.

But I hope that the veterans service organizations and the Members on this side do not lose perspective on the fact that the demands in dollars over the next 10 years for the infrastructure needs to handle the population that we have made a promise to are huge.

Today, we have \$14 billion worth of construction either let or underway and we have no idea how we are going to finish paying for that much less this horizon that we see that we know is coming. We cannot deny it. We have got to be responsive to it.

So, mine is not a judgment based upon trying to tell the VA what they should and should not do. It is to some degree facing the realities of what we have before us and asking how we can best allocate our funds and leverage our dollars in a way that fulfills the promise that we have made to all those individuals.

So, I thank the Chair for the editorial time.

Chairman SANDERS. Thank you, very much, Senator Burr.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman.

Let me begin by saying that I agree with much of what Senator Burr has just said about the challenges that we need to face and have not prepared to confront going forward simply in the numbers that will separate from the military.

I see it from the standpoint of the Committee on Armed Services where we are preparing for the downsizing of our military in numbers that are almost unprecedented in recent history.

Obviously in the wake of every war, we have downsized to some extent but this influx of needs—health care requirements as well as other kinds of challenges and obligations that we owe—they are not new obligations.

We have made promises and the Nation needs to keep faith with them. So, I welcome his statement and I know that the Chairman has spoken to it as well. But I hope that we can come together as a Committee again on a bipartisan basis and try to at least produce a blueprint for trying to deal with these issues.

Mr. Weidman, I want to say a personal thanks to you and to the Vietnam Veterans of America who have been absolutely instrumental and central in developing the Topic Exposure Research and Military Family Support Act of 2013, and I welcome additional changes after you consult with other organizations, including the DAV, and Colonel Norton, with your organization as well.

I have no pride of authorship in this bill. I have no preconceived notion of what should be in it but I think the central point is we have an obligation to provide remedies to diseases and conditions that have been passed on to children and grandchildren, as you have so eloquently said, Mr. Weidman, and also to veterans, more recent veterans from Afghanistan exposed to the burn pits, the members of families at Camp Lejeune that Senator Burr and Senator Hagan have championed.

This issue of toxic chemicals is just beginning to be understood. The fact that we expose our military men and women to these wounds of war without any real scientific knowledge and awareness or sensitivity to those issues I think is a gap that we need to remedy.

So, I think you are performing an enormous service, your organization and others, in calling attention to this very, very difficult and challenging area.

Without being too long-winded, I also want to second your point about VistA and the Department of Defense.

As long as the folks from the VA are still here, I join Senator Burr in raising some qualms about the reaction of the Department of Defense. I think I alluded to those qualms earlier.

But let me just ask you if I may, Mr. Weidman, about the Toxic Exposure Research and Military Family Support Act. I have had one of these roundtables in Connecticut. You were kind enough to join us.

Is there a national constituency for this bill in your view?

Mr. WEIDMAN. There is, Senator, and we have had since that roundtable at Rocky Hill, CT, 20 some odd meetings. There were seven just the week before last and in the same week in Florida in a round robin format, been to California; and I think that by next spring, certainly by Memorial Day, that you will have one in virtually every State in the union, at least one.

Frankly, our goal is to have one in every congressional district so people cannot say it does not affect my veterans because it sure as heck does because the exposures were so wide, when you looked at what happened to Gulf War one, Vietnam, and the young people serving today.

Senator BLUMENTHAL. Thank you. My time has expired but I again want to thank each of you for being here today for your service to our Nation and for the service that has been provided to every single member of the organizations you represent.

Thank you so much.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Blumenthal.

Let me thank the panelists and again reiterate what Senator Blumenthal said, we thank you very much for the work of your organizations. This Committee cannot do its job without learning and working with all of the service organizations.

I want to thank VA for being here as well and for their excellent testimony. I think it has been a good hearing and I thank everyone for attending.

This hearing is adjourned.

[Whereupon, at 4:25 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Mr. Chairman, thank you for holding this important hearing. The legislation being discussed today covers a wide range of important issues that will help us fulfill our solemn promises to our veterans, our servicemembers, and our military families.

I appreciate the opportunity to discuss the SCRA Enhancement and Improvement Act of 2013, which I proudly introduced this week with Chairman Sanders. The Servicemembers Civil Relief Act was first passed in 1940 as the Soldiers' and Sailors' Civil Relief Act (SSCRA), and it was designed to help make sure that that servicemembers' sacrifices for our Nation did not force them to also sacrifice their credit and their financial well-being. In the decades since, the law became known as the Servicemembers Civil Relief Act and has been amended several times.

This law goes far to assist servicemembers in a wide range of areas including protecting them from foreclosure, default judgments, and eviction. However, the Department of Justice and experts in this field have pointed to common-sense changes we can make to clarify and expand the protections that exist today. In making these changes, the law will match our intent, and make sure that common areas where military service affects servicemembers' finances and rights are not overlooked. Among other things, the improvements in our bill will protect servicemembers from being discriminated against when being considered for a loan simply because of their entitlement to rights under the SCRA; strengthen some of the foreclosure protections under existing law; and give servicemembers extra time to renew their professional licenses and meet continuing education requirements if they are deployed.

I have always been proud of this Committee's ability to work in a bipartisan fashion for the best interests of our veterans and military families. I hope this will again be the case with this legislation so we can give servicemembers critical help they earned and deserve.

LETTER FROM HON. FRANK B. AGUON, JR., CHAIRMAN, COMMITTEE ON GUAM
U.S. MILITARY RELOCATION



OFFICE OF SENATOR
FRANK B. AGUON, JR.
CHAIRMAN, COMMITTEE ON
GUAM U.S. MILITARY RELOCATION | HOMELAND SECURITY | VETERANS' AFFAIRS | JUDICIARY



30 October 2013

The Honorable Senator Bernard Sanders
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D. C., 20510

Dear Senator Sanders:

Hafa Adai (Greetings from Guam)!

As Chairman of the Committee on Guam U. S. Military Relocation, Homeland Security, Veterans' Affairs and Judiciary of the Thirty-Second Guam Legislature I would like to present testimony in support of legislation that would provide necessary and additional support to our nation's veterans. The people of Guam have over the course of history proven its patriotism to our nation in defense of freedom, with perhaps the highest per capita representation in the various wars since World War II, to include the recently concluded Operation Iraqi Freedom and the on-going Operation Enduring Freedom. Today, approximately six hundred (600) men and women of the Guam Army National Guard are serving in Afghanistan in Operation Enduring Freedom. A service that these soldiers have undertaken honorably and are proud to extend to our nation and their home island of Guam. It is only proper that the service of our nation's veterans be acknowledged, and that appropriate health services be made readily available when necessary for our veterans and their families.

Therefore, please accept this letter as testimony in support of S. 1155, Rural Veterans Mental Health Care Improvement Act, which I understand is presently being considered by your Committee. Over the years, our nation has recognized the increasing number of veterans who have been diagnosed with mental illness, and who are in need of appropriate mental health treatment. The proposed measure would provide additional professional and staff support for mental health treatment and other healthcare services that have been deemed necessary for our veterans. It is imperative that such additional services and support be provided for our veterans who have served our nation, and the island of Guam, honorably in defense of freedom.

Your positive consideration for the passage of S. 1155 in support of our nation's veterans, and in turn which would also extend to Guam's veterans, would be greatly appreciated. Should you have any questions, comments or concerns regarding Guam's veterans or the statements contained herein, please do not hesitate to contact my office at your earliest convenience. *Un Dangkolo' Na Si Yu'os Ma'ase'* (Thank you very much).

Respectfully,

SENATOR FRANK B. AGUON, JR.
Chairman, Committee on Guam U.S. Military Relocation, Homeland Security, Veterans' Affairs, and the Judiciary
Mina Trentai Dos Na Liheslaturan Guåhan (Thirty-Second Guam Legislature)

CC: The Honorable Jon Tester, Senator, United States Senate
The Honorable Madeleine Z. Bordallo, Guam Delegate, U. S. House of Representatives
The Honorable Senators, Mina Trentai Dos Na Liheslaturan Guåhan (Thirty-Second Guam Legislature)

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PREPARED STATEMENT OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES,
AFL-CIO AND THE AFGE NATIONAL VETERANS' AFFAIRS COUNCIL

American Federation of Government Employees and the AFGE National Veterans' Affairs Council (hereinafter "AFGE") appreciate this opportunity to provide a statement for the record on S. 1556, a bill to restore equal bargaining rights to health care professionals at Department of Veterans (VA) Affairs medical facilities.

AFGE represents 650,000 Federal employees. More than two thirds of the 210,000 VA employees we represent work on the front lines at VA medical facilities caring for veterans.

S. 1556 provides a long overdue fix to a gross inequity in the law that weakens the VA's ability to attract and maintain a strong health care workforce. The law in question—38 U.S.C. 7422 ("Section 7422")—also deprives veterans of full protection from improper and unsafe care. Earlier this year, a VA registered nurse and AFGE local president testified before Congress about the cover up and mishandling of a deadly Legionnaires outbreak at her facility. Yet, if a registered nurse (RN) at her facility attempted to file a grievance over excessive mandatory overtime that deprived her of adequate rest and put her patients at risk, her grievance would be blocked by current VA "7422" policy.

Section 7422 unfairly singles out VA employees in eight health care positions: registered nurses (RN), physicians, dentists, physician assistants, optometrists, podiatrists, chiropractors and expanded-function dental auxiliaries. AFGE also represents RNs, physicians and others working in these covered positions at facilities operated by the Department of Defense (DOD) and the Bureau of Prisons (BOP). These DOD and BOP employees are permitted to grieve over routine workplace issues such as the assignment of mandatory overtime and calculations of shift differential pay because they are covered by Title 5 bargaining rights, like most Federal employees.

The VA's "7422" policy also results in differential treatment between VA health care professionals working at the same facility. VA Hybrid Title 38 employees have full Title 5 bargaining rights. The result is extremely arbitrary: a VA registered nurse cannot bargain over the failure to provide adequate training when she is reassigned from primary care to the ICU while a VA licensed practical nurse can. Similarly, a VA psychiatrist cannot grieve over the loss of incentive pay while a VA psychologist can.

Opponents have argued that S. 1556 creates new bargaining rights. This is not correct: S. 1556 merely restores equal bargaining rights that were afforded to these clinicians prior to 2003. Unfortunately, over the past decade, the VA adopted a different interpretation of Section 7422 to deprive these clinicians of rights to grieve and negotiate over routine workplace matters and block complaints arising out of violations of rights under other Federal laws.

Opponents have claimed that if VA physicians and RNs (and those in the other six covered positions) have full bargaining rights, it will interfere with management's mission to provide patient care. Yet, VA management does not claim that VA Hybrid 38 employees interfere with patient care when they exercise full bargaining rights.

In fact, VA physicians, RNs, and other Title 38 clinicians working at the Captain James A. Lovell Federal Health Care Center in North Chicago already have full bargaining rights under Public Law 110-417. In 2010, when the Navy and VA merged facilities at this location, the law provided that all the DOD clinicians who became VA Title 38 employees would retain their full bargaining rights as VA employees under a pilot project for two years. To date, the VA has not made a single complaint about the impact of full bargaining rights on patient care at the Lovell Federal Health Care Center. In fact, recently, the VA extended that pilot project for an additional three years.

Title 5 affords VA management the same rights as all Federal managers to carry out the agency's mission, including the right to determine the number of employees, hire, assign, suspend and remove employees, and "to take whatever actions may be necessary to carry out the agency mission during emergencies" (5 U.S.C. 7106(a)).

Several years ago, AFGE participated in good faith in a VA working group that culminated in new VA "7422" policy. AFGE did not sign the Memorandum of Understanding that formed the basis of the new policy because it did not accurately reflect the language adopted by the working group. Although the new policy is a step in the right direction, it is a very small step that does not have the force of law. It can be revoked at any time, which is exactly what President Bush did in 2003 when he nullified a very helpful labor-management agreement reached seven years earlier.

AFGE and its National VA Council are also troubled by the VA's continued practice of refusing to bargain over matters that are covered by the new "7422" policy,

and the continued practice of local human resources personnel trying to make their own “7422” determinations, even though the law clearly states that only the Secretary can make those determinations.

Finally, too many VA Title 38 clinicians are experiencing first hand that “justice delayed is justice denied.” The Secretary has only published four “7422” determinations since the new policy took effect in 2010. The Department has still not responded to AFGE’s August 2013 information request to determine how many cases are pending. These backlogged cases involve real employees with serious workplace issues that need to be addressed.

Thank you again for the opportunity to present the views of AFGE and its National VA Council on S. 1556.

PREPARED STATEMENT OF ANTHONY A. WALLIS, LEGISLATIVE DIRECTOR,
ASSOCIATION OF THE UNITED STATES NAVY (AUSN)



1 November 2013

The Honorable Bernie Sanders (VT)
Chairman, Senate Veterans' Affairs Committee
332 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Sanders,

On behalf of the Association of the United States Navy (AUSN), we are writing to express our support of your bill S. 1583 Mental Health Support for Veteran Families and Caregivers Act of 2013, which would require the Secretary of Veterans Affairs to conduct an education program and peer support program for the education and training of family members and caregivers of veterans with mental health disorders.

Mental health is a crucial aspect of healthcare, but it can be difficult to understand and treat mental health disorders, especially for family members and caregivers. Suicide levels among Veterans have been a troubling concern for the Department of Defense (DOD) and the Department of Veterans Affairs (VA). Despite mental health conditions gaining recognition as a major concern for the general Veteran population, many mental health disorders are poorly understood and family members and caregivers can find themselves ill-equipped to address these disorders.

S. 1583 aims to establish an education program and a peer support program for family members and caregivers of Veterans with mental health disorders, which is an important step towards more effectively treating mental health disorders. Furthermore, the bill outlines a comprehensive education program to be undertaken with qualified organizations to provide appropriate training and to be made widely available to family members and caregivers. Additionally, each education program is to be accompanied by a peer support program. Each program will report back to the VA Secretary, and surveys and annual reports will gauge the effectiveness of the programs. These programs would be a much-needed step forward in addressing mental health care among Veterans.

Thank you for taking in active role in such an important issue to the Veteran community by introducing legislation that helps Veterans with mental health disorders and their families and caregivers. If you have any questions please feel free to contact me at 703-548-5800.

Sincerely,

Anthony A. Wallis
Legislative Director, AUSN

LETTER FROM WENDY SPENCER, CHIEF EXECUTIVE OFFICER, CORPORATION FOR
NATIONAL AND COMMUNITY SERVICE

1201 New York Avenue, NW
Washington, DC 20525
202-606-5000
NationalService.gov

October 30, 2013

Dear Chairman Sanders,

Thank you for inviting the Corporation for National and Community Service (CNCS) to share our views on S. 1262, the Veterans Conservation Corps Act of 2013.

As you know, CNCS is a Federal agency that engages thousands of Americans in service and volunteerism each year through the AmeriCorps and Senior Corps programs. Our programs work with a vast network of grantees and partners to get things done in communities across the country. CNCS also works with other Federal agencies to bring the unique value of national service to help them fulfill their missions. In 2012, through an interagency agreement, CNCS and FEMA created FEMA Corps, a specialized unit of the AmeriCorps National Civilian Community Corps, dedicated to providing disaster services needed by FEMA.

S. 1262 would establish a Veterans Conservation Corps to help veterans make the transition to civilian life by employing and placing them in conservation, resource management, and historic preservation projects on public lands, maintenance and improvement projects at national cemeteries, and as firefighters, law enforcement officers, and disaster relief personnel. Section 2(c)(3) would require the Secretary of Homeland Security to provide funds to increase participation by Veterans in the FEMA Corps program.

S. 1262 includes concepts similar to the Administration's Veterans Job Corps proposal, which was included in its Fiscal Year 2014 Budget. The Administration would welcome the opportunity to work with the Committee on this proposal.

Warmest regards,

Wendy Spencer
Chief Executive Officer

PREPARED STATEMENT OF KEITH KELLY, ASSISTANT SECRETARY OF LABOR FOR
VETERANS' EMPLOYMENT AND TRAINING, U.S. DEPARTMENT OF LABOR

INTRODUCTION

Chairman Sanders, Ranking Member Burr, and distinguished Members of the Committee. Thank you for the opportunity to provide the Department of Labor's (DOL or Department) views on pending legislation. I commend you all for your tireless efforts to ensure that America fulfills its obligations to our returning service-members, veterans, and their families. The Department looks forward to working with the Committee to provide these brave men and women with the employment support, assistance and opportunities they deserve to succeed in the civilian workforce.

While this hearing is focused on numerous bills pending before the Committee, I will limit my remarks to those pieces of legislation that have a direct impact on the programs administered by DOL, including the following: S. 1262, the "Veterans Conservation Corps Act of 2013," S. 1281, the "Veterans and Servicemembers Employment Rights and Housing Act of 2013," and S. 1558, the "Veterans Outreach Enhancement Act of 2013." DOL respectfully defers to other Federal Departments or Agencies with respect to the remaining pieces of legislation.

S. 1262—"VETERANS CONSERVATION CORPS ACT OF 2013"

S. 1262, the "Veterans Conservation Corps Act of 2013" would establish a "Veterans Conservation Corps," similar to the Civilian Conservation Corps, aimed at employing veterans: (1) in conservation, recreation, and resource management projects on public lands, and (2) as firefighters, law enforcement officers and disaster relief personnel. The Veterans Conservation Corps would be administered by the Department of Veterans Affairs (VA) in cooperation with the Departments of Justice (DOJ), Agriculture, Commerce, Homeland Security, Interior, and the Army Corps of Engineers.

DOL supports the intent of this bill, which includes similar concepts to the Administration's Veterans Job Corps proposal that was presented in its FY 2014 Budget. We would welcome the opportunity to work with the Committee on this bill.

S. 1281—"VETERANS AND SERVICEMEMBERS EMPLOYMENT RIGHTS AND
HOUSING ACT OF 2013"

S. 1281, the "Veterans and Servicemembers Employment Rights and Housing Act of 2013" would prohibit discrimination in employment and housing on the basis of military service. The Department supports the intent of this legislation, but defers to the Equal Employment Opportunity Commission (EEOC), DOJ, and the Department of Housing and Urban Development (HUD) on sections of the bill that fall outside the Department's purview. We do, however, have some technical concerns with section 2 of the bill, as drafted, and look forward to working with the Committee to address these concerns and enhance employment protections for veterans and members of the Armed Services, Guard and Reserve.

DOL administers and enforces a number of laws that protect American workers and ensure that they are treated fairly on the job. Among these important worker protections are the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), Section 4212 of the Vietnam Era Veterans' Readjustment Assistance Act (VEVRAA) and the provisions relating to veterans preference in Federal employment under Title 5 of the U.S. Code. Through USERRA and other laws, DOL works tirelessly to ensure that the men and women who serve this Nation are protected against adverse discrimination based on their past, present, or future military service obligations.

The Department has concerns with how section 2, which is modeled after Title VII of the Civil Rights Act of 1964, would interact with the Department's existing authorities that protect against discriminatory employment actions. In our view, this could be confusing for both claimants and employers, and could yield inconsistent results. The Department gladly would work with the Committee, and our fellow agencies, to ensure that the important aims of S. 1281 are achieved without adversely impacting existing protections.

S. 1558—"VETERANS OUTREACH ENHANCEMENT ACT OF 2013"

DOL defers to the VA on the substance of the legislation, but has a technical concern with the provision on outreach activities related to USERRA. More specifically, in section 2, paragraph (d)(2)(D), the Secretary of Veterans' Affairs is given authority "to enter into agreements with other Federal and State agencies to carry out

projects under the jurisdiction of such agencies” to “educate communities and State and local governments about the employment rights of veterans, including the employment and reemployment of members of the uniformed services under chapter 43 of title 38, United States Code.” Due to the highly complex and technical nature of USERRA, DOL is concerned about ensuring consistency in any educational outreach program. DOL therefore believes that the bill should be amended to require that any applicable outreach be conducted in coordination with the Department.

CONCLUSION

The Department of Labor is committed to providing our veterans, transitioning servicemembers, and their families with the best possible employment services, protections, and programs our Nation has to offer. Mr. Chairman, Ranking Member Burr, and Members of the Committee—this concludes my statement. Thank you again for the opportunity to submit this statement for the record.

PREPARED STATEMENT OF BRYAN GREENE, ACTING ASSISTANT SECRETARY FOR THE OFFICE OF FAIR HOUSING AND EQUAL OPPORTUNITY, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Chairman Sanders, Ranking Member Burr, and Members of the Committee, I am pleased to have this opportunity, on behalf of the U.S. Department of Housing and Urban Development (HUD), to discuss S. 1281, the Veterans and Servicemembers Employment Rights and Housing Act of 2013. S. 1281 proposes to protect Veterans and Servicemembers from housing discrimination, by making certain amendments to the Fair Housing Act (hereafter Housing Act, or Act). The Office of Fair Housing and Equal Opportunity, of which I am the Acting Assistant Secretary, has the primary responsibility for enforcing and administering the Housing Act. We strive to prevent discrimination through outreach and education, but when housing discrimination occurs we do not hesitate to take enforcement action against those that violate the law.

Each year my office, and our state and local partners investigate more than 8,000 complaints of housing discrimination based on race, color, religion, sex, national origin, familial status, and disability. Far too many of these cases involve veterans—often, they are veterans who encounter discrimination based on injuries that they sustained during their service. In one case, a Vietnam veteran alleged his housing complex denied him permission to have his companion dog live with him, which he needed because of a disability. Following an investigation, the Department negotiated a conciliation agreement, whereby the owner and apartment management company agreed to pay \$10,000 to the veteran. In another case, HUD charged a Utah homeowners association for allegedly discriminating against a Gulf War combat veteran with psychiatric disabilities when it refused his request to keep an emotional support dog. In February 2012, the Justice Department obtained a settlement with the homeowner association that awarded the veteran \$20,000 and required the homeowner association to implement a new reasonable accommodation policy and train its staff on the requirements of the Housing Act. Other cases have included allegations of refusing to make reasonable accommodations for veterans with Post Traumatic Stress Disorder (PTSD) or refusing to rent to a veteran because of PTSD.

Currently, the Housing Act does not prohibit discrimination based specifically on veteran or military or veteran status, and as such, HUD brought all the foregoing cases on the basis of the Act’s current prohibitions against “disability” discrimination. As such, we do not have a definitive or comprehensive count of discrimination on the basis of veteran or military status. However, under the Department’s Fair Housing Assistance Program, HUD partners with 95 State and local agencies that administer fair housing laws that are substantially equivalent to the Act, and five state agencies and eight local agencies in the program administer laws that include protections for servicemembers and veterans. Through the program, the agency is able to provide civil-rights protections for just those servicemembers and veterans living in those jurisdictions.

The Housing Act is a national civil rights statute that provides protections based on race, color, religion, sex, national origin, familial status, and disability. There have been a number of proposals in recent years to amend the Act, to make it unlawful to discriminate on the basis of sexual orientation, gender identity, marital status, and source of income. We believe that further study should be given to ascertain how best to address these issues.

HUD agrees that members of our military who risk their lives overseas should not encounter obstacles related their military service as they search for a home upon their return. We would be happy to work with our State and local partners

that currently provide these protections to gather information on the frequency of this discrimination and to provide any assistance with can to assist the Committee in crafting the best way to combat this kind of discrimination.

PREPARED STATEMENT OF IRAQ & AFGHANISTAN VETERANS OF AMERICA

Bill #	Bill Name	Sponsor	Position
S. 875	Department of VA Disease Reporting & Oversight Act	Casey	Support
S. 1148	Veterans Benefits Claims Faster Filing Act	Heinrich	Support
S. 1155	Rural Veterans Mental Health Care Improvement Act	Tester	Support
S. 1165	Access to Appropriate Immunizations for Veterans Act	Tester	Support
S. 1211	A bill to prohibit the use of phrases GI Bill and Post-9/11 GI Bill to give a false impression of approval...	Boxer	Support w/ Conditions
S. 1216	Improving Job Opportunities for Veterans Act	Bennet	Support
S. 1262	Veterans Conservation Corps Act	Nelson	Support
S. 1281	Veterans and Servicemembers Employment Rights and Housing Act	Blumenthal	No Position
S. 1295	A bill to require the Secretary to provide notice that relevant services may be available from VSOs	Brown	Support
S. 1296	Servicemember's Electronic Health Records Act	Nelson	Support
S. 1361	World War II Merchant Mariner Service Act	Murphy	No Position
S. 1399	A bill to amend the SCRA to extend the interest rate limitation on debt entered into during military service...	Durbin	Support
S. 1411	Rural Veterans Health Care Improvement Act	Franken	Support
S. 1434	A bill to designate the Junction City CBOC as the LTG Richard J. Seitz Community-Based Outpatient Clinic	Moran	No Position
S. 1471	Alicia Dawn Koehl Respect for Nat'l Cemeteries Act	Coats	Support
S. 1540	A bill to include contracts and grants for residential care for veterans in the exception...	Brown	Support
S. 1547	Veterans Dialysis Pilot Program Review Act	Burr	No position
S. 1556	A bill to modify authorities relating to the collective bargaining of employees in the VHA	Brown	No Position
S. 1558	Veterans Outreach Enhancement Act	Begich	Support
S. 1559	Benefits Fairness for Filipino Veterans Act	Durbin	No Position
S. 1573	The Military Family Relief Act	Tester	Support
Draft 1	A bill to update the Service-Disabled Insurance program to base premiums rates...	Sanders	Support
Draft 2	A bill to provide replacement automobiles for certain disabled veterans and members of the Armed Forces	Sanders	No Position
Draft 3	Veterans Health Care Eligibility Expansion and Enhancement Act	Sanders	No Position
Draft 4	Enhanced Dental Care for Veterans Act	Sanders	Support

Bill #	Bill Name	Sponsor	Position
Draft 5	Mental Health Support for Veteran Families and Caregivers Act	Sanders	Support
Draft 6	Medical Foster Home Act	Sanders	Support
Draft 7	SCRA Enhancement and Improvement Act	Sanders	No Position
Draft 8	Improved Compensation for Hearing Loss Act	Sanders	Support
Draft 9	Survivors of Military Sexual Assault and Domestic Abuse Act	Sanders	Support
Draft 10	Toxic Exposure Research and Military Family Support Act of 2013	Blumenthal	No Position
Draft 11	A bill to expand eligibility for reimbursement for emergency medical treatment to certain veterans ...	Hirono	Support
Draft 12	The Improving Quality of Care Within the Department of Veterans Affairs Act	Burr	Support

Chairman Sanders, Ranking Member Burr, and Distinguished Members of the Committee: On behalf of Iraq and Afghanistan Veterans of America (IAVA), I would like to extend our gratitude for the opportunity to share with you our views, thoughts, concerns and recommendations regarding these important pieces of legislation.

IAVA is the Nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and their supporters. Founded in 2004, our mission is critically important but simple—to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of nearly 270,000 members and supporters, we strive to help create a society that honors and supports veterans of all generations.

In partnership with other Veteran Service Organizations (VSO), IAVA has worked tirelessly to see that veterans' needs and concerns are appropriately addressed by the Department of Veterans Affairs (VA) and by Congress. IAVA appreciates the efforts put forth by this Committee to address the issues and challenges facing our Nation's veterans and their families. We stand with you in supporting legislation to continue improving the services offered by VA, empowering veterans to improve their lives after military service, and ensuring that veterans are fully aware of all the benefits available to them as our Nation begins transitioning away from more than a decade of war in Iraq and Afghanistan.

IAVA is, therefore, able to offer its support for many of the bills that are the subject of this hearing today because we believe that they would better enable the VA to live up to its commitment on behalf of the American people.

S. 875

IAVA supports S. 875, the Department of Veterans Affairs Disease Reporting and Oversight Act, which would require directors of Veterans Integrated Service Networks (VISNs) to report confirmed cases of certain infectious diseases at Veterans Health Administration (VHA) facilities. In addition, plans to prevent the spread of infectious diseases must be established and implemented following the notification of infection.

As currently written, Title 38 does not contain obligatory reporting requirements for infectious diseases. The need for established reporting and prevention protocols is clear following numerous infectious disease deaths at several VA medical facilities over the past year. In response to these deaths, the VA has released VHA Directive 2013-008, which requires VA medical facilities to follow state laws on reporting infectious diseases similar to those that private and non-profit medical centers must follow. But it is also important for Congress to codify such reporting requirements.

This legislation seeks to include a list of agencies, personnel, and employees that are required to be notified within 24 hours when certain infectious diseases are confirmed at a VA medical facility. IAVA believes that responsible reporting of such occurrences and outbreaks and a comprehensive plan to prevent the spread of such diseases is an essential aspect of preventing future unnecessary deaths.

S. 1148

IAVA supports S. 1148, the Veterans Benefits Claims Faster Filing Act, which would require the Secretary of Veterans Affairs to provide and post information,

both at VA facilities and on the Internet, regarding average claims processing times and the percentages of claims filed via each of the various claims intake methods.

In order to help facilitate the transition to a 21st century VA, IAVA supports utilizing electronic processes for more efficient claims processing and information dissemination. Educating veterans on the most efficient filing methods will help streamline the claims process and assist the VA in reducing the claims backlog. This legislation aims to establish prominent public displays about the differences in types of claims-filing pathways in order to ensure that all veterans are making informed decisions regarding the claims filing process. IAVA supports this bill because it will provide veterans with more information on the claims process and will help veterans make an informed decision about how to best file their claims.

S. 1155

IAVA supports S. 1155, the Rural Veterans Mental Health Care Improvement Act, which would provide advance appropriations for specific information technology accounts within the VA, include education and training for additional types of therapists and counselors, expand the definition of mental health services, and require the VA to report on the status of telemedicine services.

The need for advance appropriations for additional aspects of the VA was clear during the most recent government shutdown. Not only were veterans left wondering when the services they need would resume, but VA employees were also left to wonder when they could return to work and training. In today's technology-dependent world, the need for an adequately funded and functioning information technology infrastructure is obvious, and providing advanced appropriations for this aspect of the VA's operations is vital to helping the department continue to function during future shutdowns. IAVA believes that advance appropriations for all VA accounts is necessary, but this legislation would at least ensure that additional aspects of VA's infrastructure could continue operating in spite of the political environment.

IAVA also supports educating and training additional mental health professionals and counselors to meet the various needs of veterans and their families. Specifically, this bill would include training and education for marriage and family therapists as well as licensed professional mental health counselors. Well-trained mental health professionals and counselors provide quality counseling options for veterans in need of these services, and educational opportunities for these professionals at the VA should be expanded.

Additionally, this bill would require the Secretary of Veterans Affairs to report on issues currently hindering the provision or expansion of telehealth services by the VA. Since telehealth services rely heavily on technology, the implementation of such services presents some challenges for rural veterans. The report would include the scope of challenges the VA is experiencing and what the VA is doing to address these challenges. IAVA supports understanding these challenges and establishing methods to address them so that better health care options will be available for all veterans regardless of location.

S. 1165

IAVA supports S. 1165, the Access to Appropriate Immunizations for Veterans Act of 2013, which would expand what immunizations are covered by the VA. This legislation seeks to include all immunizations listed on the adult immunization schedule published by the Center for Disease Control and Prevention (CDC).

As currently written, Title 38 allows for immunization coverage, but does not specify which immunizations will and will not be covered within its section on definitions. This bill aims to utilize the CDC's dynamically updated immunization schedule to develop a uniform standard of the immunizations that will be covered by the VA. The CDC's schedule for immunizations is already used by healthcare professionals and insurance agencies to determine when and which immunizations are recommended. IAVA supports the use of the CDC's immunization schedule for the VA as well in order to remove the ambiguity on covered immunizations currently in Title 38.

S. 1211

IAVA supports the intent of S. 1211, a bill which would prohibit the use of the phrases "GI Bill" and "Post-9/11 GI Bill" by any company, organization, or individual as it relates to promotions, goods, services, or commercial activity so as to give a false sense of approval or endorsement by the VA without the written consent of the Secretary of Veterans Affairs.

IAVA recognizes the need to safeguard veterans against fraudulent and misleading services, goods, and promotions in regards to the GI Bill and Post-9/11 GI Bill educational benefits. However, it is unclear to IAVA if whether VSOs, other non-profit organizations, and useful projects and initiatives such as IAVA's NewGIbill.org would also be prohibited from utilizing the phrases "GI Bill" and "Post-9/11 GI Bill" without approval. IAVA feels the bills current language is too exclusionary, and we encourage the Committee to address these concerns.

S. 1216

IAVA supports S. 1216, the Improving Job Opportunities for Veterans Act of 2013, which would improve and increase on-the-job training programs and apprenticeship opportunities for veterans in the private sector and in the Federal Government.

The transition from the military to the civilian workforce continues to be a struggle for many veterans. Creating opportunities for veterans to learn new civilian skills through on-the-job training and apprenticeships would help create an even stronger veteran workforce. This legislation would create training opportunities that veterans need, and IAVA supports the continued effort to help veterans successfully transition to civilian careers.

S. 1262

IAVA supports S. 1262, the Veterans Conservation Corps Act of 2013, which would create a Veterans Conservation Corps to employ veterans in conservation, historic preservation, resource management, National Cemetery Administration projects, and as fire fighters, law enforcement personnel, and disaster relief personnel.

Too often veterans leave military service and face difficulty securing civilian careers. Recent reports from the Bureau of Labor Statistics show the post-9/11 veteran unemployment rate to be 10.1%, and the unemployment rate among veterans aged 18–24 is an alarming 22.8%. Reducing these percentages is a priority for IAVA, and we support legislation to directly address veteran unemployment. While there are programs in existence to assist veterans in transition, a Veterans Conservation Corps would go one step further by creating more opportunities to continue to serve. IAVA supports this legislation because it would help veterans develop skills that can be used for continued civilian careers.

S. 1281

IAVA has no position on S. 1281, the Veterans and Servicemembers Employment Rights and Housing Act of 2013. Although IAVA strongly supports the fair and equitable treatment of veterans, at this time IAVA has no organizational position on this legislation.

S. 1295

IAVA supports S. 1295, which would require the VA to post information about the services and assistance available from VSOs so that veterans who file electronic claims will be more aware of the services available to help them in applying for benefits.

VSOs have well established programs to assist veterans with submitting claims, but veterans are not always aware of these services. Therefore, they do not always avail themselves of such services. IAVA supports this bill because it takes advantage of a key engagement opportunity with veterans to inform them of outside services that they may find helpful.

S. 1296

IAVA supports S. 1296, the Servicemembers' Electronic Health Records Act, which would establish a timeline for the implementation of interoperable electronic health records.

Interoperability between the Department of Defense (DOD) and VA medical records systems is a key component in establishing a smooth transition for veterans from DOD health care to VA health Care. IAVA supports the establishment of a reasonable timeframe for making implementing this mandate.

S. 1361

IAVA takes no position on S. 1361, which would designate those who served as Merchant Mariners during WWII as veterans for the purpose of providing these individuals and their family members with access to certain benefits afforded to vet-

erans. While we understand and acknowledge that there is an ongoing debate within the veteran community about whether to bestow veteran status and benefits on other categories of individuals who served our Nation in various capacities during previous periods of conflict, we defer to that debate and to our colleague veteran and military service organizations—whose memberships and constituencies this would impact more—on this issue.

S. 1399

IAVA supports S. 1399, which would amend the Servicemembers Civil Relief Act (SCRA) to allow pre-service private or Federal student loan debt to be refinanced or consolidated while retaining the 6% rate cap afforded under SCRA.

In order to qualify for the Public Service Loan Forgiveness Program, servicemembers with a Federal education loan or a Perkins student loan must consolidate their pre-military service loans. The forgiveness program rewards borrowers who have made regular payments for ten years while in public service, including service in the military. Specific language in SCRA shields servicemembers from costly interest rates by capping their interest rates at 6% on loans that were initiated prior to their military service. Should a servicemember choose to refinance his or her student loan, that individual would no longer be eligible for the interest rate cap afforded under SCRA.

This legislation would fix this loophole by allowing student loan debt accrued prior to military service to be consolidated or refinanced while maintaining the 6% interest rate cap offered on pre-service debts through SCRA. This change effectively allows servicemembers with a Perkins loan or other Federal education loans to enter into the Public Service Loan Forgiveness Program, and thus better manage their personal finances.

S. 1411

IAVA supports S. 1411, the Rural Veterans Health Care Improvement Act of 2013, which would improve access to and quality of health care services for veterans in rural areas.

A significant number of our Nation's veterans seeking access to VA health care live in rural areas, yet these areas lack some of the typical medical facilities to which many other veterans living in more densely populated areas have easier access. Even though community-based outpatient clinics seek to provide more convenient health care access for rural veterans, these men and women are still not always getting the treatment and access tailored to their particular medical needs.

This bill would seek to ensure that rural veterans' access to health care is significantly improved by requiring VA to produce a five-year strategic plan that demonstrates how VA will recruit and retain health care professionals in rural areas, how VA will ensure the successful and timely delivery of its services through contract and fee-basis providers, and also how it will implement and expand the use of telemedicine services in rural areas.

S. 1434

IAVA has no position on S. 1434, a bill that would designate the Junction City Community-Based Outpatient Clinic in Junction City, Kansas as the Lieutenant General Richard J. Seitz Community-Based Outpatient Clinic. As a standard practice, IAVA typically does not take a position on bills whose sole purpose is to designate or name facilities. However, IAVA fully supports efforts to honor servicemembers and veterans who have had exemplary careers, have accomplished outstanding achievements, and/or have made extraordinary sacrifices for our country.

S. 1471

IAVA supports S. 1471, the Alicia Dawn Koehl Respect for National Cemeteries Act, which would give the VA the authority to disinter veterans buried in national cemeteries that committed of a Federal or state capital crime.

In 2012, Michael Anderson, an Army veteran, shot and killed Alicia Dawn Koehl before committing suicide as the police were arriving. After discovering that Mr. Anderson was buried with full military honors at a national cemetery in Michigan, the Koehl family requested that Mr. Anderson's remains be exhumed, since Federal law prohibits those who have committed a capital crime but were unavailable for trial due to death from being given the honor of a burial in a national cemetery. Upon review, the VA determined that it does not have the legal authority to disinter a veteran. Therefore, this legislation is needed in order to give the VA this authority and rectify this problem.

IAVA believes that the Koehl family's wish ought to be legislatively enabled in order to bring this family closure and a sense of justice and to ensure that the VA is not stuck in this situation again in the future. Individuals who commit heinous capital crimes against their fellow citizens do not warrant a resting place on the same hallowed ground as our Nation's most honored heroes.

S. 1540

IAVA supports S. 1540, a bill which would make state homeless facilities eligible for more Federal grants. Federal law allows state veterans homes to operate under three categories (domiciliary care, nursing home care, or hospital care). Because state veterans homes are not permitted to receive other Federal funds, they are not eligible for grants under VA's Health Care for Homeless Veterans Program. In order to more effectively address veteran homelessness, veterans homeless shelters should be afforded greater flexibility to receive such funding, which this bill seeks to achieve.

S. 1547

At this point in time, IVA has no position on S. 1547, a bill that would require VA to ensure that its dialysis pilot program is not expanded until it has been implemented at its initial facilities, an independent analysis of the program has been conducted, and VA has provided a report to Congress detailing progress of the program.

S. 1556

At this point in time, IVA has no position on S. 1556, a bill which would address the collective bargaining rights of employees at the Veterans Health Administration (VHA). Although IVA strongly supports the recruitment and retention of quality VA employees, it has no organizational position on this legislation.

S. 1558

IAVA supports S. 1558, the Veterans Outreach Enhancement Act of 2013, which would require the VA to partner with local veterans organizations in an effort improve outreach to veterans in certain areas of the country.

Too many men and women leaving the military are not enrolling in the VA and are failing to utilize the care and services they need. Currently, the burden is largely on these veterans to acquire information access their benefits. Expansion and enhancement of VA's outreach at the state and local levels is necessary in order to provide these veterans with key information about the services, programs, and benefits available to them in order to ensure that they are taking full advantage of everything VA has to offer. This bill will also provide states and local veterans organizations with grants in an effort to incentivize improvements in outreach to local veteran populations.

Fully bringing America's newest generation of veterans into the VA will require an unprecedented outreach effort, and the Veterans Outreach Enhancement Act of 2013 is the first step in getting us there.

S. 1559

At this point in time, IVA has no position on S. 1559, the Benefits Fairness for Filipino Veterans Act of 2013, which would address residency requirements for certain veterans of World War II. As always, IVA is incredibly humbled by and appreciative of the service and patriotism of those who fought for our country in a time of war across all generation.

S. 1573

IAVA supports S. 1573, the Military Family Relief Act, which would automatically provide temporary compensation to a surviving spouse of a veteran upon the death of the veteran.

As this Committee is fully aware, filing a claim with the VA can become a lengthy ordeal and can leave servicemembers, veterans, and their family members waiting in anguish for a response of some kind. In order to ensure that the bereaved family members of deceased servicemembers and veterans are not forced to endure any more anguish, the Veterans Benefits Administration (VBA) should be given the ability to provide dependency and indemnity compensation (DIC) and other related benefits to the family automatically, instead of being forced by law to cutoff the disability pay and pension upon the veteran's death and requiring the surviving spouse to re-file. This cumbersome and unnecessary step adds more hardship to spouses at

a difficult time in their lives, and efforts to ensure that these individuals are compensated with ease is an objective that IAVA supports.

DRAFT BILL 1 (SEN. SANDERS)

IAVA supports this draft legislation, which would base Service-Disabled Veteran Insurance premium rates on the Commissioners 2001 Standard Ordinary Table of Mortality as opposed to the Commissioners 1942 Standard Ordinary Table of Mortality.

The Commissioners Standard Ordinary Tables of Morality (CSO) are used to calculate life insurance non-forfeiture values and are also used by the VA to calculate premiums for the Service-Disabled Veteran Insurance program available to veterans with a service-connected disability. As currently written in Title 38, the VA utilizes a CSO from 1941, which provides antiquated numbers to calculate life insurance premiums and non-forfeiture costs. IAVA supports this bill to update the CSO to the 2001 version in order to arrive at more accurate and updated estimates of life insurance non-forfeiture costs and premiums.

DRAFT BILL 2 (SEN. SANDERS)

At this point in time, IAVA has no position on this draft legislation, which would provide replacement automobiles for certain disabled veterans and servicemembers under certain specific circumstances. IAVA has been a proponent of streamlining the regulations and processes for veterans and servicemembers receiving care and assistance from the VA. However, we are still reviewing this newly drafted legislation and look forward to finding out more about how the changes it makes would improve the lives and livelihoods of veterans.

DRAFT BILL 3 (SEN. SANDERS)

At this time, IAVA has no position on the Veterans Health Care Eligibility Expansion and Enhancement Act of 2013, which would require VA to provide for the enrollment of certain veterans who otherwise do not have access to health insurance while also expanding eligibility for veterans to enroll in VA health care.

The VA should be the primary one-stop shop for the services and benefits that veterans have earned. Providing quality care for veterans of Iraq and Afghanistan requires an innovative approach that address both the mental and physical health of a veteran. We must continue to expand efforts to connect more veterans to vital health care resources, however IAVA would prefer to further analyze this legislation in order to better provide this Committee with our thoughts and views about proposed reforms dealing with changes to whether veterans qualify for treatment as low-income families, as well as the contracts VA enters into for the purposes of rendering health care services.

DRAFT BILL 4 (SEN. SANDERS)

IAVA supports the draft bill entitled the Enhanced Dental Care for Veterans Act, which would extend allowable dental services to veterans who are hospitalized or in a nursing home, who have previously received dental services, and who need those services to restore functioning lost as a result of the previous dental services. Additionally, this bill would establish educational programs on dental health and establish a means for private sector dental providers to supply the VA with relevant dental records to be included in patient electronic medical records, when necessary. IAVA supports increasing dental coverage provided to veterans in the care of the VA and supports the educational programs in conjunction with this dental care to help veterans understand how to maintain dental health and is, therefore, able to support this legislation.

DRAFT BILL 5 (SEN. SANDERS)

IAVA supports the draft bill entitled the Mental Health Support for Veteran Families and Caregivers Act, which would establish education and peer support programs for family members and caregivers of veterans with mental health disorders.

These programs would help family members and caregivers learn best practices for providing care to veterans with mental health disorders, including general education on mental health disorders, techniques for handling crisis situations, and information on additional services. Training and education on handling crisis situations for family members and caregivers could help in addressing the the suicide and crisis situations that too many veterans experience. In conjunction with the educational programs, peer support groups would also be established to provide family members and caregivers a network of support. Providing daily care for a veteran

experiencing mental health disorders can bring stress upon the family and caregivers, and IAVA supports providing resources and a safe outlet for coping with this stress.

DRAFT BILL 6 (SEN. SANDERS)

IAVA supports the draft bill entitled the Medical Foster Home Act, which would allow the VA to cover the costs associated with care at a medical foster home.

Medical foster homes are a long-term health care option for veterans and provide access to trained caregivers in a residential setting. The VA does not currently provide or pay for medical foster homes, but it does regularly inspect, approve, and refer veterans to such facilities. The needs of veterans vary greatly, and medical foster homes provide additional health care options for veterans who may be uncomfortable in other long term care settings.

DRAFT BILL 7 (SEN. SANDERS)

At this point in time, IAVA has no position on the SCRA Enhancement and Improvement Act, which would improve and update several aspects of the Servicemembers Civil Relief Act (SCRA). IAVA has certainly been a proponent of protecting servicemembers from undue civil and financial burdens caused by military service. However, we are still reviewing the specific enhancements and improvements to the SCRA referred to in this bill and look forward to finding out more about these potential changes.

DRAFT BILL 8 (SEN. SANDERS)

IAVA supports the Improved Compensation for Hearing Loss Act, which would require the Secretary of Veterans Affairs to submit reports on the findings and actions taken to address a 2006 Institute of Medicine and the National Academies report on hearing loss and tinnitus caused by military service. Since hearing loss and tinnitus remain a frequent problem for veterans, a better statistical understanding of these issues will help establish best practices for addressing these types of disabilities. This bill would also require reports detailing the level of cooperation between the DOD and VA on hearing loss, and ways in which the two can cooperate in the future. IAVA supports cooperation and continuity between DOD and VA health care, and hopes to see continued cooperation in the future.

DRAFT BILL 9 (SEN. SANDERS)

IAVA supports the Survivors of Military Sexual Assault and Domestic Abuse Act, which would allow VA to provide counseling and treatment for sexual trauma to members of the Armed Forces, require VA to screen veterans for domestic abuse, and require VA to submit reports on military sexual trauma and domestic abuse.

Sexual assaults in the military have increasingly become a high-profile issue; in 2012, according to a Pentagon report, an estimated 26,000 servicemembers experienced unwanted sexual contact, 7,000 more than in 2010. In an effort to ensure that all victims of military sexual trauma have adequate care and counseling available to them, this legislation expands VA's coverage to include active duty servicemembers as well as members of the National Guard and Reserves. This legislation will not require a servicemember to obtain a referral before receiving care and counseling, a provision that would provide victims with easier access to such critical care and counseling.

The bill would also require VA to develop a screening mechanism for veterans seeking VA health care to determine if any of these individuals have been victims of domestic abuse. Given the high likelihood that instances of domestic abuse are significantly underreported, proactive screening for such abuse is an initiative that IAVA stands behind.

DRAFT BILL 10 (SEN. BLUMENTHAL)

At this time, IAVA has no position on the Toxic Exposure Research and Military Family Support Act of 2013, which would establish a VA medical center as the national center for appropriately dealing with the health conditions of descendants of servicemembers exposed to toxic substances.

The lasting effects of exposure to toxic substances are yet to be fully documented and without data tracking the health and well-being of deployed servicemembers and their families, it will be more difficult to in the long term to treat the dependents who are suffering because of their family member's exposure. Veterans of the wars in Iraq and Afghanistan are not the only ones who have fought to see VA recognize and provide compensation for exposure to toxic substances during overseas

deployments. Vietnam veterans long complained about the effects of Agent Orange exposure and were only recently granted VA disability benefits based on the diseases they contracted because of it. Likewise, Gulf War veterans have fought for decades for recognition of and reimbursement for the multiple maladies that make up Gulf War illness.

The VA has already acknowledged that there is a link between some birth defects in children with a parent that was exposed to certain toxic substances. This bill would seek to ensure that family members have the necessary facilities already identified and appropriately staffed to handle the medical needs of those whose ailments can be traced to their family member's exposure to toxic substances. IAVA will continue to review and analyze the Toxic Exposure Research and Military Family Support Act in order to better provide this Committee with its thoughts and views about establishing a national center focused on research, treatment, and diagnosis of illnesses that manifest in the descendants of those exposed to toxic substances.

DRAFT BILL 11 (SEN. HIRONO)

IAVA supports this draft legislation, which would expand eligibility for reimbursement for emergency medical treatment to certain veterans that were unable to receive care from VA in the 24-month period before the emergency care was administered.

As currently written, VA requires veterans to meet a specific and cumbersome eligibility requirement in order to ensure that they will cover the expenses a veteran accrues when receiving emergency medical treatment at a non-VA facility. This eligibility criteria indicates that veterans must not only have been enrolled in the VA health care system, but that they must have been seen by a VA health care professional within the last 24 months. Since veterans are often subjected to lengthy wait times that prevent them from obtaining an initial appointment sooner rather than later, veterans' claims for reimbursement would be denied.

By providing an exception to the 24-month requirement, this legislation would provide veterans with a level of financial certainty and peace of mind at a point in time when they should be solely focused on seeking medical assistance. IAVA believes veterans should not have their financial stability adversely impacted by an outdated requirement and by lengthy wait times for appointments.

DRAFT BILL 12 (SEN. BURR)

IAVA supports the Improving Quality of Care Within the Department of Veterans Affairs Act of 2013, which would require VA to ensure its policy on reporting cases of infectious diseases is current and up-to-date and would require an independent assessment of the Veterans Integrated Service Networks (VISN) and VA medical centers.

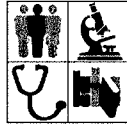
Following the deaths of five veterans across several in the VA medical centers in Pennsylvania due to an outbreak of legionnaires' disease, subsequent reporting has indicated that a lack of communication and coordination—along with VA officials' failure to follow internal policies—allowed the disease to spread, leaving veterans and their family members in the dark about the extent of the outbreak. This legislation would require VA to ensure that it has an up-to-date policy on reporting infectious diseases in accordance with state and local laws. VA will also be required to craft performance measures to ensure that VISN officials are complying with the updated policy. Finally, an independent third-party will conduct its own oversight to scrutinize VA medical centers, planning amongst VISN officials, and other standard business operations to ensure that VA is providing quality health care.

VA officials need to prove to veterans, Congress, and the public that their ability to render care is unquestionable, and the oversight authored in this legislation seeks to achieve that aim.

Mr. Chairman, we at IAVA again appreciate the opportunity to offer our views on these important pieces of legislation, and we look forward to continuing to work with each of you, your staff, and the Committee to improve the lives of veterans and their families.

Thank you for your time and attention.

PREPARED STATEMENT OF INFECTIOUS DISEASES SOCIETY OF AMERICA

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October 28, 2013

The Honorable Bernie Sanders
Chairman, Senate Veterans Affairs Committee
332 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Richard Burr
Ranking Member, Senate Veterans Affairs Committee
217 Russell Senate Office Building
Washington, DC 20510

Dear Senators Sanders and Burr:

On behalf of the Infectious Diseases Society of America (IDSA), I write in support of legislation that would require Veterans Administration (VA) healthcare facilities to report notifiable infectious disease cases to public health agencies, just as all states and most localities require all other healthcare facilities to do. We believe that such a law is urgently needed to ensure that public health officials are promptly alerted to disease outbreaks and to protect America's veterans and their communities.

IDSA represents nearly 10,000 infectious diseases physicians and scientists devoted to patient care, prevention, public health, education, and research in the area of infectious diseases. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, antibiotic-resistant bacterial infections such as those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE) and Gram-negative bacterial infections such as those caused by *Acinetobacter baumannii*, *Klebsiella pneumoniae*, and *Pseudomonas aeruginosa*, and emerging infections.

A robust infectious disease surveillance network requires a strong collaboration of federal, state, and local public health and healthcare entities. Without active and ongoing communication across jurisdictions, the public will continue to be at greater risk of infectious disease outbreaks. The 2011-2012 *Legionella* outbreak associated with the Pittsburgh VA is just one example of the danger posed to veterans, their families, and their communities by not reporting notifiable infectious diseases to public health entities. The first case of Legionnaires' disease definitively linked to the hospital was diagnosed a full year before the VA warned the public. In the end, 22 VA patients were infected in both the facility and the community, and at least five veterans died. Prompt reporting of such cases could help limit the spread of disease and the impact on patients.

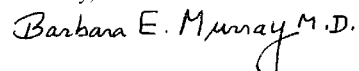
PAGE TWO—IDSA Letter to Senate Veterans Affairs Committee on ID Reporting

To prevent tragedies like this from occurring again, IDSA calls upon the Senate Veterans Affairs Committee to quickly advance legislation that would require VA facilities to report to the appropriate entity each case of a notifiable infectious disease or condition that is diagnosed in accordance with the laws of the state in which the facility is located. Such a law would simply hold all VA health facilities to the standard that all other health facilities in the state must meet and thus ensure a stronger, better coordinated public health system. Ultimately, this requirement would improve the ability of federal, state, and local public health agencies to promptly respond to and contain deadly disease outbreaks in communities across the country.

We are encouraged that the VA has issued an internal directive requiring disease reporting and, indeed, many facilities have routinely done so. While this is a sign of good faith and a clear acknowledgment that such reporting accords with sound public health practice, we believe that a statutory requirement is necessary to ensure that all VA facilities report in a timely and accurate manner. However, we do not believe that VA facilities should be exposed to the threat of civil action, and we oppose including such a provision in legislation. The VA has clearly indicated its willingness to cooperate with a reporting law, and states have rarely, if ever, resorted to litigation to enforce notifiable infectious disease case reporting among non-VA healthcare facilities.

Thank you for your efforts to protect the health and wellbeing of veterans and their families. We would be happy to discuss this issue with you and your staff as you move this important legislation forward. Should you have any questions, please contact Jonathan Nurse, IDSA Director for Government Relations, at jnurse@idsociety.org or 703-299-0202.

Sincerely,

Handwritten signature of Barbara E. Murray M.D. in black ink.

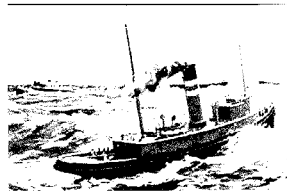
Barbara E. Murray, MD, FIDSA
President, IDSA

Cc: Senator Bob Casey

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LETTER FROM J. DON HORTON, PRESIDENT, WW II COASTWISE MERCHANT MARINERS

IN SUPPORT OF
S. 1361 WW II MERCHANT MARINERS SERVICE ACT



TESTIMONY TO THE
US SENATE VETERAN AFFAIRS COMMITTEE

In support of
S 1361 WW II MERCHANT MARINERS SERVICE ACT

Submitted on Behalf of
WW II Coastwise Merchant Mariners

On
30 OCT 2013
@10: AM



The Honorable Bernie Sanders
Chairman
Senate Veterans' Affairs Committee
412 Russell SOB
Washington, DC

The Honorable Richard Burr
Ranking Member
Senate Veteran's Affairs Committee
Russell SOB
Washington, DC

30 Oct, 2013

Dear Chairman Sanders and Ranking Member, Richard Burr,

Thank you for allowing me the opportunity to submit testimony in support of S 1361, and the forgotten services of some 10 to 30 thousand members of the Merchant Marine who sailed on coastwise barges and tugs during World War II. Most have gone unrecognized for their gallant service in defense of this country when all were needed to support our troops overseas and keep the enemy from our doors. S 1361 would finally correct the travesty of not recognizing the service of these individuals and give the few remaining men and women a shot at gaining recognition as veterans. The WW II Coastwise Merchant Mariners wish to submit this information as testimony to the committee for consideration with a recommendation to move this bill forward for adoption.

The United States Merchant Marine have been almost exclusively viewed by the general population as large ships sailing across oceans and seas carrying exotic cargo from one country to another. Little information to what actually takes place within the service is known or understood by the public. Most citizens have little knowledge that our Merchant Marine was established before our United States Navy or Coast Guard, and many do not know that during our nation's wars our Merchant Marine is looked upon as the Fourth Arm of Defense.

As you know, the United States' effort to fight and win the greatest war in history was comprised of a coalition of civilians and service members from the greatest generation this nation has ever known. There were three major components in that coalition, our fighting forces overseas, the civilian production machine here at home and, the United States Merchant Marine that served as the link.

Our Merchant Marine has proven itself time and again in every war we have encountered. History has consistently noted the brave seamen who crossed oceans carrying our troops and war materials in every war, and who often encountered enemy actions that sent many of those brave souls to the bottom of the seas. Stories have been written about their heroic efforts to keep our shipping lanes open even while losing ships enemy hostilities here on our own shores during World War II. At times, during World War II, we were losing our ships faster than they could be built. The commanders of the German U-boats considered the waters off the east coast to be a shooting gallery because of our lack of security and adherence to keeping our shoreline dark. The bright lights from the various amusement parks and residential areas along the coastal beaches provided the perfect backdrop for German U-boats to pick our ships off at will.

We fought World War II on a global scale, with major fighting on three fronts. Logistics for this war in terms of supplies reached a scale never since matched. The supply lines to our front lines stretched across both oceans. They were very vulnerable, especially at the very start of the war. Our nation was caught off guard by the magnitude of the logistical effort required to maintain our front lines. Every effort was made to keep our troops adequately supplied by working around the clock in our defense plants. Every able bodied person, rather it be man, woman or child stood up to do their part. This nation came together like no other time to produce the supplies required to keep that war effort moving forward. This effort has not been matched since, and probably will never be again.

The task of transporting our troops and the majority of materials overseas fell to our Merchant Marine. The United States had a very small inventory of ships that could carry our troops and supplies, and the German U-Boats were sinking them faster than we could build new ones. Enemy submarine successes threatened the outcome of the war in the first few years. In fact, the loss of shipping along our coastline during the first part of the war was so great that our own government had to step in and instruct our news outlets not to give out the number of ships lost. There was fear that our seamen would refrain from shipping out, thereby creating critical manpower shortages. This would have caused shipping delays and quite possibly could have placed our chances of winning the war in jeopardy. Had it not been for the gallant efforts of merchant seamen manning vessels against threatening odds, the war could have ended much differently.

The great loss of ships caused our nation to call upon another group of vessels that had generally been placed out of service. Our country had some 250-300 old wooden hulled barges that were rarely used. Most had long passed their effective life span. Some were built around the middle of the nineteenth century and their condition was poor. Many barges began their life as sail schooners in the mid-1800s. There was a short-lived belief that sails would help propel these barges and give the tugboats towing them a little help. By the turn-of-the-century most had their masts removed and extra hatches added to the hulls to carry more cargo.

There were some seventy companies that did business in the coastal trades, and about 700 barges or schooners were recorded as actively participating. Records indicate the first wooden hulled barge was built around 1856 and maybe the last around 1923. They ranged in sizes in tonnage from 600 to 2400 tons. During World War II there may have been a little more than a few hundred barges remaining to carry out this tradition.

After the turn of the 20th century, companies began to send the barges out into larger bodies of waters. Soon the coastwise trade for barges was where the money was for companies. A tow of three barges could carry more payload of, say coal, than several locomotives could carrying 300 coal cars or 600 trucks carrying the same payload and at a fraction of the cost.

Shortly after the outbreak of World War II, it became apparent that we needed every possible source of commerce to keep our supplies lines open. These barges were quickly called back into service even in their very old and primitive conditions. It was not uncommon to see ten or twenty tugs and their barges moving cargo up and down the coast on any given day. As demand for commerce grew the barges began playing a larger role in the defense of our country. After all, no other mode of transportation could offer the benefits at lesser costs. They were by far the most economical means to move product around the country.

The German U-boats sank our ships faster than we could build them. Larger and faster ships were needed to keep our shipping lanes open and to keep our troops overseas supplied with badly needed materials. Here at home, every available means of moving war materials to our defense plants became a necessity, regardless of the risk.

These barges kept alive a tradition dating back before the birth of this nation. Our forefathers brought this lifestyle with them when they landed here to establish this country. Families were traditional on some of the barges. This emanated from the river barges that traveled the major tributaries of our nation for as long as this nation has existed. Our major source of commerce came by river throughout our country. Often the crew that manned some of these barges during the summer school breaks was comprised solely by families. Companies who owned these barges looked favorably on those that were manned by families. It was believed families would remain on board more so than single seamen mainly because of the primitive living conditions generally found on most barges. Families tend to adapt more easily.

Barge seamen endured a life that was extremely primitive as most barges were without the average necessities found ashore. There was no electricity, running water or the usual bathroom conveniences. Heat came from a simple coal stove that was used for cooking as well. Light from kerosene lamps was the norm. This life was hard and it left its mark on you. With the ever present German U-boats, young seamen matured fast. This was a far cry from a young man's dream of sailing the 7 seas.

These coastwise barge seamen were a small, dedicated and mostly unknown group who served in the US Merchant Marine. They made little news but played a very important role during World War II. They moved bulk cargo and war supplies to the various defense factories and power plants along the East Coast. Minimal news or entries in history were made as most gave little attention to them. They were considered by many as insignificant. Historians wrote limited information and they would only make news if something disastrous happened. Storms would cause sufficient damage and some would make the news if fatalities occurred. History passed them by and carried their records along with it.

Since the younger and more able-bodied seamen preferred the large more modern ships, barges were more or less left to others less traditional crews. Some elderly seamen came back to the sea and brought their families to serve as members of the crew. This brought forth a resurgence in the traditional use of barge families. Many women who were refused opportunities to work on the larger vessels came aboard the barges as crew as well. Some of the seamen that came to work on the barges were without the credentials now required to prove service on these vessels. They

worked alongside those with credentials and were paid the same wages with the same taxes withheld. They performed the same work and were exposed to the same threats as the certified seamen were. Yet, today, many of the seamen that operated tugs and barges cannot prove their service because they do not have the proper documents those others were provided. Many were directly denied documents because of their age, gender or disability. Today we call this discrimination.

Many seamen were considerably older than the required draft age and often disabled. Many were missing a leg, arm or an eye. School age children manned the crew positions as well as any other seamen. They proved their mettle. These barges carried the bulk raw war materials to the ports that fed the defense plants that built war supplies and equipment for our troops overseas. The use of these barges freed our larger merchant fleet to concentrate on the vital necessity of transporting supplies and equipment to our troops on the front lines. This was not a small task.

At the start of the war, women tried repeatedly to join the US Merchant Marine. They were thwarted by the War Shipping Administrator (WSA), Admiral Emory S. Land who declared that there was no place in the Merchant Marine for women. By this order from the WSA, the US Coast Guard refused to document women who served. Women served anyway and performed every duty asked of them, without any formal recognition for their work. They served on barges and other vessels, mostly as cooks and messmen. They were paid salaries and Social Security taxes were taken from their wages. They performed the same services as those with proper credentials on the same vessels and did it well. They deserve to be recognized for their service to our country.

Efforts to gain status as seamen by the women were met with stern denials from the Captains of the Port (COTP) stationed at the various coastal ports. I was present in June of 1942, when the COTP of New York denied my mother and sister their official documentation as seamen. Instead he issued an official US Coast Guard Identification Card to my mother and told her my sister did not need one as she was below the age of 16. Children could move about freely through the security checkpoints on the docks if accompanied by a parent. He stated by order of the WSA, he was directed to deny official seaman's papers to women upon application.

Thousands of other women were denied official documentation for service in the Merchant Marine. To this day, there has been no way for these women to gain their due recognition as seamen of the United States Merchant Marine and thus gain veterans status of this nation. A letter from the US Coast Guard dated 09 Apr, 2010, states, "The US Government did not issue mariner credentials to females during World War II."

Recent research of 29 barges and tugs brought forth over 1100 seamen who served between 1942 and 1943. From that group there were 87 seamen with traditionally female names who served aboard those vessels. That transmits to a ratio of almost 9 percent of the work-force being women, if one could use this finding to be an approximate ratio of seamen who served on coastwise vessels. In today's military service, where women are recognized for their service, the ration is placed at 14%. This finding provides an astounding proportion of women serving during World War II in the Merchant Marine that have never been officially recognized as seamen and veterans. This is wrong and it needs to be corrected. Passing S-1361 would remedy this shameful situation.

Other research has brought forth two other actions that have inhibited seamen who served in the Merchant Marine during World War II from seeking recognition as veterans. The Commandant of the US Coast Guard's order of 20 Mar 1944 relieved the masters of tugs and seagoing barges of the responsibility of issuing shipping and discharge papers to seamen. Then, the US Maritime Administration issued orders to destroy ship's deck and engine logbooks in the 1970s. A US Coast Guard Reference Information Paper #77 dated April, 1990 refers to these actions.

World War II brought about the advent of women in the military and they proved themselves. They earned some of our country's highest honors for their service. However, the women who served in the US Merchant Marine in World War II were denied their Official Mariner's credentials and have never been able to achieve what they most gallantly earned, veteran status. Those of us who hold this status perceive it as one of our most honored possessions.

On 23 July, 2013, Senators Chris Murphy, Richard Blumenthal of CT and Susan Collins of ME introduced a bill in the Senate that may help these coastwise seamen and women gain what has been denied them for more than 67 Years. S 1361, the World War II Merchant Mariner Service Act would direct the Secretary of Homeland Security to allow other forms of documentation to prove service in the World War II Merchant Marine. Official Records have

either been withheld, destroyed, or denied, thus preventing somewhere between 10,000 to 30,000 coastwise merchant seamen from gaining their rightful place as veterans of our country.

The WW II Coastwise Merchant Mariners offer the following specific information in support of S 1361, and to demonstrate the need for this legislation:

RATIONALE FOR HR 1288 “WW II MERCHANT MARINERS SERVICE ACT”

Findings 1: The US Merchant Marine Seamen of WW II gained veteran status under a court ruling via Schmacher, Willner, et al, V. Secretary of the Air Force Edward C. Aldridge, Jr 665 F Supp 41 (D.D.C 1987) providing they meet certain eligibility requirements.

Findings 2: USCG Information Sheet #77 (April 1992) identifies **acceptable forms of documentation** for eligibility meeting the requirements pursuant to Schmacher V. Aldridge, 655 41(D.D.C 1987)

- a. Certificate of Discharge (Form 718A)
- b. Continuous Discharge Books (ship's deck/engine logbooks)
- c. Company letters showing vessel names and dates of voyages

Findings 3: Some 10,000 to 30,000 coastwise seagoing tug and barge merchant seamen have been or may be denied recognition upon application because actions taken by government agencies (prior to P. L. 95-202) have removed required eligibility records from being available to the veteran.

Findings 4: Commandant USCG Order of 20 March, 1944 **relieves masters** of tugs, towboats and seagoing barges **of the responsibility of submitting reports of seamen shipped or discharged on forms 718A**. This action removes item (a) from the eligibility list in Findings 2.

Findings 5: USCG Information Sheet # 77 (April, 1992) further states “Deck logs were traditionally considered to be the property of the owners of the ships. After World War II, however, the deck and engine logbooks of vessels operated by the War Shipping Administration were turned over to that agency by the ship owners, and **were destroyed during the 1970s**”. This action effectively eliminates item (b) from the eligibility list in Findings 2.

Findings 6: Company letters showing vessel names and dates of voyages are highly suspect of ever existing due to the strict orders prohibiting even the discussion of ship/troop movement. Then consider item (c) of Findings 2 should be removed from the eligibility list. USCG Info Sheet # 77, page 2 refers

Findings 7: Commandant, USCG Ltr 5739 of 09 Apr 2010 states, “**The US Government did not issue mariner credentials to females during the World War II.**” And “**The NMC now processes requests for DD 214s as a part of their normal business practices.** This **removes cost to prepare documents for veteran leaving no costs required.**”

Findings 8: CBO preliminary cost report of 10 June, 2013: “The costs associated with the attached bill language have an **insignificant** effect on direct spending over the 2014 to 2023 period”. They are considered **De Minimis**.

Findings 9: Excerpts from Pres. Roosevelt’s fireside Chat 23: On the Home Front (Oct. 12, 1942): “In order to keep stepping up our production, we have had to add millions of workers to the total labor force of the Nation. In order to do this, we shall be compelled to use **older men, and handicapped people, and more women, and even grown boys and girls**, wherever possible and reasonable, to replace men of military age and fitness; **to use their summer vacations, to work somewhere in the war industries.**”

Findings 10: After the Revolutionary War many Acts of Congress were enacted to provide pensions to those veterans applying for support. Thousands of servicemen were without documented service and remained without

any viable means to prove service. Excerpts from documents retained at the NARA provide: Generally the process required an applicant to appear before a court of record in the State of his or her residence to describe under oath the service for which a pension was claimed. This sets precedence for using certified oaths in conjunction with the Social Security documents as alternative documentation.

Findings 11: The USCG cannot provide a true estimate of Merchant Mariners serving in World War II. GAO/HEHS-97-196R refers. Estimates range from 250,000 to 410,000 from recognized historians. None of these historians were aware of these 10,000 to 30,000 coastwise merchant seamen where many served without proper credentials and did not include them in their above estimates... Some were elderly handicapped; others women and some were school children who served in a billet, drew wages and paid taxes. They served on the same vessels in the same hostile war zones and performed the same services alongside others who were documented. Yet, only about 90,900 merchant mariners have been recognized as veterans with just 1192 of these veterans are in receipt of compensation or pension benefits. This is a vast disparity in ratio of the other service branches.

Findings 12: DOD and NARA Agreement N1-330-04-1 of Jul, 08, 2004 puts in place a procedure to transfer military personnel files of individuals from all services, (including civilian personnel or contractual groups who were later accorder military status under the provisions of Public Law 95-202). This agreement affects military personnel records of individuals 62 years after separation from service. Action has taken place for all except the US Merchant Marine IAW P.L 95-202. This inaction by the **Department of Homeland Security via (COMDT USCG)** has caused many of the mariners to have gone unrecognized for their services. Many have passed without ever gaining recognition or benefits and soon all will be History. Only about 90,000 out of 250,000 have ever received recognition as veterans with many unable to gain access because of age and health condition requiring assistance for others outside family. Had compliance taken place, these records would be available to all and providing the mariner a chance to being recognized many years ago and enjoying the benefits awarded to them via public law.

Whereas: (1) by court order, Schumacher v. Aldridge 665 F Supp 41 (D.D.C. 1987) provided for veteran status to certain US Merchant Marine seamen during WW II (07 December, 1941 to 31 December, 1946) with the same benefits accorded all veterans as administrated by the VA.

Whereas: (2) President Roosevelt's speech of 12 Oct, 1942 puts in place the use of elderly and handicapped individuals, school children and women in an effort to support war efforts by replacing men of military age and fitness, and in stepping up our production of war materials for those on the front lines.

Whereas: (3) DOD & NARA Agreement N1-330-04-1 of July 08, 2004 provides for the transfer of military records to the National Personnel Records Center, St. Louis, MO for use as archival records, open to the public. But no action has taken place by the DHS for the mariner in almost 9 years causing the veteran loss of due access of his records that may accord him recognition as a veteran.

Whereas: (4) HR 1288 provides for alternative records to be used in place of records lost, destroyed or denied for coastwise seamen affected and allow women and school children be recognized for their services rendered for the first time ever.

Whereas: (5) Costs for this bill is considered **De Minimis** via Findings 8 removing cost as a consideration.

Together we can make a difference as these brave seamen did for us during WW II. They stood up for us and in doing so they kept this country free. The very least we can do is repay them with the recognition they have most graciously deserve. Let's stand up for them and make it possible for them to gain their rightful position as veterans. Will you help make it happen?

As President of the WW II Coastwise Merchant Mariners I represent the group not only as a whole but for the many generations of children whose ancestors are among those that have passed over the bar and most have no knowledge of what tremendous services their loved ones provided to our nation. I can speak for the men, women and children who manned the barges during WWII because I was one of them and from firsthand experience, I know we are deserving and have been overlooked after giving so much for the war effort and **Freedom**. The tugboat Menomonee was sunk off the coast of Virginia on 31 Mar., 1942 at 37° 34' N, 75° 25' W by the German U-boat 754, with the loss of my brother, William Lee Horton, Jr. at the age of 17, while serving his country.

Below is a summary of my family's approximate time in service during WW II. Many families had as much service as we did but I have been unable to document them to the extent of my own family from firsthand experience:

William Lee Horton Family

Name	Date of Birth	Death Date	Seaman Z No	Position Held
William Lee Horton	12/06/1894	02/17/70	Z 187260	Master
Sadie Owney Horton	11/25/1899	12/08/98	429571// 031*	Cook
William Lee Horton, Jr	11/17/1924	03/31/42	Z 245 185	Able Seaman
Jack Oswald Horton	01/19/1929		Z 474 431	Master
James Donnell Horton	03/03/1932		Z 474 532	Able Seaman
Doris Jean Horton	01/28/1927	03/06/94	Not Available	Messman

- Sadie Owney Horton was **denied** seaman papers in New York City, NY by the Maritime Commission Office when she filed for seaman's papers in 1942. They informed her that they were not accepting women in the Merchant Marines at that time. This was their **policy**. They issued her a formal USCG identification, depicted above, and were directed to use that for work.

WW II WAR ZONE STATISTICS

Calculations: Average Days at Sea per trip

Roundtrip: **10 to 14 days** Single trip: **3 to 5 days** Per Month: **5 single or 2.5 round trips**

	<u>Months</u>	<u>Years</u>	<u>Round</u>	<u>Single</u>	<u>Days</u>	<u>Years</u>
<u>Name</u>	<u>Service</u>	<u>Service</u>	<u>Trips</u>	<u>Trips</u>	<u>at Sea</u>	<u>at Sea</u>
William Lee Horton	61	5.1	153	306	918 to 1515	2.51 to 4.15
Sadie Owney Horton	36	3.0	90	180	540 to 900	1.48 to 2.47
William Lee Horton, Jr	04	0.4	13	26	78 to 130	0.21 to 0.36
Jack Oswald, Horton	32	2.7	80	160	480 to 800	1.32 to 2.19
James D. Horton	18	1.5	45	90	270 to 450	0.74 to 1.23
Doris Jean Horton	03	0.33	12	24	60 to 80	0.20 to 0.22
Collective TOTALS:	153	12.93	393	786	2346 to 3805	6.46 to 10.66

Note: Trips usually originated in Hampton Roads, VA loading a cargo of war materials, (ore, scrap metals, sugar, salt, lumber, coal, etc.). Destination of these barges pointed north. Ports visited, to off load the cargo, were many with the nearest to Hampton Roads, VA being Philadelphia, PA and reaching as far north as Nova Scotia. These ports included Detroit, MI; Stamford, CT; Bridgeport, CT; Hartford, CT; New Haven, CT; New London, CT; Providence, RI; New Bedford, MA; Fall River MA; Boston, MA, Portland, ME; Halifax, Nova Scotia and others. There were **786** trips made that should have resulted in **786 discharges**.

Consider: Days at sea were days spent in the presence and fear of enemy submarines continuously. Waters off the US East Coast were a war zone 24/7 and merchant ships were constantly being attacked by German submarine Wolf packs. These tows moved at a pace of 2 to 6 knots and were sitting ducks for the taking. Threat of being attacked by the enemy submarines was constant. Captain W. L. Horton spent the equivalent of 3 years on these treacherous sub infested waters. Sadie O'neley Horton spent about 2 years. The siblings together spent about 2.7 years in this Atlantic host also. This was a significant courageous wartime undertaking for any family and recognition for their magnificent and heroic services and the sacrifices they made for our country should be noted. Collectively, the Horton family spent 12.9 years in US Merchant Marine during WWII with over 8 years traveling those waters heavily infested with those hostile German submarine wolf packs that spread havoc on the US Merchant vessels. There were few military units that endured more than this length of time in any war zone, ever.

BARGES for HORTON FAMILY

OWNER: SOUTHERN TRANSPORTATION CO. COMMERCIAL TRUST BLDG. PHIL. PA
APPROX

Name	Year Worked	Gross Tons	Year Built	Hull Number	Builder	Location
TUCKAHOE	1940	1267	1913	165394		CHES. CITY, MD
TENNESSEE	1941	1327	1918	167417		CHES. CITY, MD
COHASSETT	1941-2	21229	1893	27655		CLEVELAND, OH
CHELSEA	1942-3	1327	1919	218878	KELLLEY, SPEAR, CO	
PORTLAND	1943-4	2129	1919	167794	MISSOURI VALLEY BRIDGE & IRON	QUANTICO, VA

OWNER: CULLEN TRANSPORTATION CO. 80 BROAD ST., NEW YORK, NY; SOC SEC EMPLOYER
NO # 13-5017994

CULLEN #17	1945	1371	1917			
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OWNER: P. DAUGHERTY CO. GAY & LOMBARD STS. BALTIMORE, MD; EMPLOY #52-0296180

MARYLAND	1945	1371	1917	214687	AMERICAN CAR & FOUNDRY Co.	SOUTH PORTLAND, ME
DELAWARE	1946	1371	1916	166194	AMERICAN CAR & FOUNDER CO.	SOUTH PORTLAND, ME
BALTIMORE	1947	1371	1916	214479	GILDERSLEEVE SHIP	GILDERSLEEVE, CT
PROVIDENCE	1948	1371	1917	215749	AMERICAN CAR & FOUNDRY COM	SOUTH PORTLAND, ME

Additional Barges one or more of the Horton family served on before, during and after WWII

Name	G/Tons	Built	Number	Company
Allegany	2298	1921	167100	P. Daugherty Co.
Fredcrick	2301	1921	166621	P. Daugherty Co.
Montauk	1371	1915	21374	P. Daugherty Co.
Charles J. Hooper	2217	1922	222439	Eastern Transp. Co.
Bango	2129	1919	167793	Southern Transp. Co.

Chester	1327	1919	164514	Southern Transp. Co
Cohasset	2129	1922	27655	Eastern Transp. Co.
Monokin	1287	1919	219409	Southern Transp. Co.
Orinoco	1287	1919	165033	Southern Transp. Co.

PORTS VISITED WWII Timeframe between Dec 07, 1941 to Dec 31, 1946

Baltimore, MD	Bangor, ME	Boston, MA	Fall River, MA
Hoboken, NJ	New Bedford, MA	New Haven, CT	New York, NY
Norfolk, VA	Palisades, NY	Perth Amboy, NJ	Philadelphia, PA
Portsmouth, NH	Providence, RI	Stamford, CT	Williamston, NC



PHOTO: (1)) "Don Horton, age 12, 1944" (2) Mom & Dad, circa 1943 (3) Mom on "Cohasset" 1942

S 1361 could help some gain recognition as a veteran. This legislation can correct a travesty that has gone unnoticed or ignored for such a long time. Costs associated with this bill have been deemed **to have an insignificant impact on direct spending** by the CBO so cost should **not** be an issue. This bill stands alone in helping these coastwise merchant seamen gain recognition that they have been deprived of due to records being withheld, destroyed, or denied. This needs to be corrected and soon. These seamen are leaving us at an alarming rate. If not now it will all be for history. We need to stand up and do what is right for these seamen. We must do what is right and support this bill.

Thank you again for allowing me the opportunity to provide you some history and reasoning as to why S 1361 is needed. I hope this is presented in a manner that you now understand what this small group did to assist this nation when all were needed to keep us free from the enemy during a very bleak time for our country. They did what was right for our country and now we need to do what is right for these seamen.

On behalf of the WW II Coastwise Merchant Mariners I respectfully request that you move this bill S-1361 out of your committee and to the floor with unanimous approval thus showing our nation that yes we do remember our veterans.

Very Respectfully,

J. Don Horton

J. Don Horton, President
WW II Coastwise Merchant Mariners
104 Riverview Ave, Camden, NC 27921

Ph: 252 336 5553

LETTER SUBMITTED BY PAUL J. KOEHL & FAMILY IN SUPPORT OF
S. 1471, THE ALICIA DAWN RESPECT FOR NATIONAL CEMETERIES ACT

Indianapolis, IN, October 15, 2013.

*U.S. Senate,
Washington, DC.*

DEAR SENATORS,

It has happened again! Despite the best efforts of Senator Barbara Mikulski and Senator Larry Craig in 2006 and 2007 to enact a law ensuring that those veterans who commit capital crimes not be afforded the privilege of burial with military honors in the hallowed grounds of our National cemeteries, the injustice continues.

My name is Paul J. Koehl of Indianapolis, IN. I am a 45 year old father of two children, Victoria 13 and Thomas 12. In May 2012, I became a widower. Mere words cannot begin to describe the feelings of loss, loneliness, and grief my children and I experience on a daily basis. Only someone who has dealt with the inexplicably brutal slaying of a loving spouse could possibly understand.

On May 30, 2012, my dear wife and loving mother of our two children, Alicia Dawn Koehl, was mercilessly gunned down as she sat at her desk during a mass shooting at the Indianapolis apartment complex where she was newly employed as an assistant sales manager. Alicia was shot an unthinkable 13 times by an angry tenant whom she had never met. She died at the scene. After shooting Alicia and three other individuals, the shooter committed suicide with a single self-inflicted gunshot to the head after being confronted by the police. Loaded clips of ammunition in the killer's possession indicate that the shooting spree was far from over had the police not arrived so quickly and acted so bravely. The killer was U.S. Army veteran, Michael Lashawn Anderson. Needless to say, the hearts and lives of my children and I, as well as those of my entire family, continue to be haunted by the senseless acts of violence carried out by Michael Lashawn Anderson on that day.

My beloved wife of 16 years, Alicia Dawn, was the glue that held our family together. She was an extremely warm and giving member of the community as well. Being an extraordinarily kind and loving wife and mother, she was a faithful member of St. Pius Catholic Church, "Volunteer of the Year" and PTO president at Spring Mill Elementary where our children attended school, an excellent amateur photographer, and devoted Girl Scout leader. Her smile and gentle nature never failed to light up a room. One of her coworkers, a shooting victim himself, was quoted as saying, "In the few weeks since Alicia started working here, she made it a pleasure to come to work." She always put the needs of others before her own. Often her "me" time was spent contributing time and effort to charitable activities, often utilizing time with her girlfriends to participate in events such as the Mud Run. For those of you not familiar, this is a combination obstacle course, human steeple chase event held in a mud bog for the sole purpose of raising funds and awareness for the Susan G. Komen Foundation's Race for the Cure.

Alicia's life revolved around our family. Her near expert photos line the walls and her motto "Live, Laugh, Love" appears in nearly every room in our home. She loved sports and her role as a sports mom, encouraging our daughter Victoria at gymnastics competitions and our son Thomas at hockey tournaments. She was even known to schedule the time we attended church on Sunday based upon kickoff time of that day's Indianapolis Colts football game. She would always say she couldn't wait to watch the Colts with Thomas, Victoria, Daddy, and Harley (the family dog).

A candlelight vigil organized by family friends and the staff of Spring Mill Elementary School was held on the Friday following her death. School Principal Sabha Balagopal said of Alicia "She had a zest for life. Her sense of humor and laughter lifted our spirits and made our PTO meetings so much fun." A friend and co-worker said "I don't understand why the people who die are always the brightest lights." At the June 4th session of the Indianapolis City/County Council, a motion to "close the meeting in recognition, respect, and appreciation for the life and contributions of Alicia Dawn Koehl" was made by Councilor Scales and is now forever a part of the permanent record. Council President, Maggie Lewis added, "America has been made great by those persons who have made landmark contributions, as well as those whose very presence in the community is a stabilizing influence which lends a sense of purpose and direction." That was my Alicia.

Unbeknownst to us, at the same time we were laying my Alicia to rest, her killer was "mistakenly" being given a military burial at Fort Custer National Cemetery in Battle Creek, Michigan in direct violation of 38 U.S.C. 2411. We were informed of this injustice several weeks later when a family friend Googled Anderson's name. It turned out that not only had Anderson committed this heinous crime in Indianapolis, he also had pending charges and a criminal record in his home state of Michi-

gan. Prior to Anderson's military burial, no one bothered to check these easily accessed facts, or if they did, they chose to ignore them. Adding further insult, both Alicia's father and Brother served in the United States Marine Corps. Her father, Sgt. Ronald Lunte was a bronze star decorated veteran of two tours in Vietnam. Imagine how the revelation that their daughter's murderer had received a military burial must have felt in the Lunte household.

We have made every effort to go through all of the proper channels in our effort to get this injustice resolved. We have contacted the Fort Custer Cemetery personnel, The Indianapolis Mayor's Veteran Affairs Liaison, and finally the Office of Veteran Affairs in Washington D.C. in an attempt to have Alicia's killers remains removed from Fort Custer National Cemetery. Our requests moved slowly through VA channels eventually arriving at the desks of Undersecretary Steve Muro and Secretary Eric K. Shinseki, both in the office of Veterans Affairs. Even a direct appeal to Secretary Shinseki, personally delivered by a family friend, West Point graduate, Airborne Infantry Commander, and veteran of two tours of duty in Vietnam was not enough to move those in positions of authority to correct their error.

In late July of this year, the VA and their lawyers assumed the stance that they "lacked the authority" to reverse the illegal burial of Michael Lashawn Anderson. Passage of the Alicia Dawn Respect for National Cemeteries Act will provide the Department of the Army and the Veterans Affairs Office with the explicit authority they say they lack. This will give them not only the authority to "do the right thing" and correct this latest outrage, but also give them the tools they need to prevent similar painful events from occurring in the future.

Generally, our family holds our Nations veterans in the highest regard and have been regular contributors to the Disabled Veterans of Indiana, however, when a veteran such as Michael Anderson commits a Capital crime, he strips himself of this honor and should summarily forfeit any and all benefits bestowed upon honorable veterans, including the benefit of a military burial. It does a great disservice to all of our Nations veterans when a murderer like Michael Anderson is allowed to be interred in a place of honor alongside men and women who have given of themselves for the protection of all that this Nation holds dear, and lived their post service lives as upstanding members of our communities.

Perhaps our West Point/Vietnam veteran friend stated it best when he said, "Military honors burial is not a RIGHT, but rather a PRIVILEGE earned by your subsequent conduct as well as your previous service. Service to my country was a privilege and as a combat veteran, all I expect is 6 feet of hallowed ground from the country that I love. Men like Michael Anderson DISHONOR that privilege!"

In helping to pass similar legislation in December 2006 which resulted in the required removal of the remains of just such a person from Arlington National Cemetery, Senator Barbara Mikulski stated that "she was proud to not only have helped them (the Davis Family) but to have created a law to ensure that nothing like this ever happens again." Please Google the Arlington National Cemetery Web site for "Russell Wayne Wagner" for more complete details. It would appear today that much of her effort has been for naught. It would seem likely that, if not given the explicit responsibility and "authority" to correct such errors, the VA will continue, without regard for justice OR previous legislation, to continue to provide taxpayer funded military honors burials to known killers and perpetrators of like Capital crimes.

Please prevent the insult to injury inflicted upon families of victims killed by veterans due to improper military burials. We respectfully request that you support passage of S-1471, The Alicia Dawn Respect for National Cemeteries Act, to provide the Office of Veterans Affairs not only the responsibility, but also the clear authority to correct, if not eliminate, this kind of error in the future. This would avoid this type of dishonor not only toward the families of victims, but toward all of our rightfully honored veterans.

Through this positive step, at least in some small measure, Alicia's death will not have been in vain, but instead, an instrument for justice and peace for our family as well as the families of future victims of veterans turned Capital criminals.

To quote Dr. Martin Luther King, "It is always the right time to do the right thing!" Now is one of those times.

Thank you!

Sincerely,

PAUL J. KOEHL AND FAMILY

PREPARED STATEMENT OF BRAD SLAGLE, PRESIDENT,
NATIONAL ASSOCIATION OF STATE VETERANS HOMES

IN SUPPORT OF S. 1540

Chairman Sanders, Ranking Member Burr and Members of the Committee: Thank you for the opportunity to submit testimony on behalf the National Association of State Veterans Homes (NASVH) in support of S. 1540, legislation introduced by Senator Sherrod Brown of Ohio to remove legal and financial barriers that effectively prevent State Veterans Homes from operating homeless veterans programs.

NASVH is an all-volunteer, non-profit organization whose primary mission is to ensure that each and every eligible U.S. veteran receives the benefits, services, long term health care and respect which they have earned by their service and sacrifice. NASVH also ensures that no veteran is in need or distress and that the level of care and services provided by State Veterans Homes meets or exceeds the highest standards available. The membership of NASVH consists of the administrators and senior staffs at 146 State Veterans Homes in all 50 States and the Commonwealth of Puerto Rico.

Mr. Chairman, the State Veterans Homes system is a mutually beneficial partnership between the States and the Federal Government that dates back more than 100 years. Today, State Homes provide over 30,000 nursing home and domiciliary beds for veterans and their spouses, and for the gold-star parents of veterans. Our nursing homes assist the VA by providing long-term care services for approximately 53 percent of the VA's long-term care workload at the very reasonable cost of only about 12 percent of the VA's long-term care budget. VA's basic per diem payment for skilled nursing care in State Homes is approximately \$100, which covers about 30 percent of the cost of care, with States responsible for the balance, utilizing State funding and other sources. On average, the daily cost of care of a veteran at a State Home is less than 50 percent of the cost of care at a VA long-term care facility. The VA per diem for adult day health care is approximately \$75 and the domiciliary care rate is approximately \$42 per day.

The bill before the Committee, S. 1540, has been drafted by Sen. Brown in consultation with NASVH to address a problem in Title 38 that effectively prevents State Homes from operating homeless veterans programs, even when a Home has excess capacity that could be used to help fight the pernicious problem of homelessness amongst veterans. According to the Department of Housing and Urban Development, on any given night there are over 60,000 homeless veterans, and more than twice that many experience homelessness at some point each year. This shameful fact led VA Secretary Shinseki to make ending homelessness amongst veterans by 2015 one of his highest priorities and enactment of S. 1540 could add State Veterans Homes to his arsenal of tools in that effort.

Mr. Chairman, some State Homes currently have unused bed capacity in their domiciliary programs that could be used to operate homeless veterans programs. For example, the Ohio Veterans Home in Sandusky, Ohio has both a 427 bed nursing home program and a separate 300 bed domiciliary program. While the nursing home program has a 98 percent or higher occupancy rate, the domiciliary is currently operating at less than 60 percent occupancy, leaving more than 125 beds available at any given time. The administrators at Sandusky have been exploring ways to use a small number of their unused domiciliary beds to help homeless veterans.

However, eligibility requirements for admission to the Ohio Veterans Home domiciliary program limit or restrict admission for most homeless veterans. To be admitted to the domiciliary, a veteran must provide a current medical history and physical completed by a physician, along with detailed financial documentation demonstrating need for this assistance, as well as other information. Often homeless veterans lack the resources to obtain such information required for possible admission so the Ohio Veterans Home has been looking for other ways to use their facility to support homeless veterans.

Learning about VA's Health Care for Homeless Veterans (HCHV) program, which provides grants to community homeless programs, the Sandusky Home drew up plans for a small homeless program using HCHV funding as a source of support. Under this proposed program, they would be able to admit homeless veterans without the tighter domiciliary requirements, allowing them immediate access to food, shelter, primary care, social services and other services. There are also a number of recently deployed veterans that may need a stable transition facility for post-acute care but who don't fall into the admissions criteria outlined in the VA domiciliary care program regulations. Because homeless veterans generally need more intense services initially to help them to stabilize and adjust, the Home also developed plans to work collaboratively with the VA Homeless Coordinators in an effort

to help the veteran with any specific needs they may have, which could include education, job training and long term housing.

After approaching VA with this proposal, the Sandusky Home was told that under Title 38 regulations, State Homes are only authorized to use their federally-supported homes to operate three programs: skilled nursing care, adult day health care and domiciliary care. According to VA's Office of General Counsel, if a State Veterans Home applied for and received a grant to operate a homeless veterans program, VA would have to recapture a portion of the construction grant funding previously awarded to the State Home over the past twenty years. This recapture of Federal funds would be such a severe financial penalty that it would effectively prevent any State Veterans Home from even considering a homeless veterans program.

To remove this obstacle, S. 1540 would amend the recapture provisions (38 U.S.C. § 8136) by providing an exemption for State Homes that receive a contract or grant from VA for residential care programs, including homeless veterans programs. This provision would not require VA to award grants or contracts to State Homes; VA would retain the authority and discretion to determine when and where it might make sense for a State Home to use a portion of its empty beds to help homeless veterans. Nor would it open the door to State Homes converting domiciliary programs into homeless veterans programs on their own; only VA's decision to provide funding through a grant or contract would exempt them from the recapture provisions.

S. 1540 would create opportunities for some State Homes with underutilized bed capacity in their domiciliary programs to apply for VA grants to that excess capacity to operate a homeless veterans program, thus providing additional support for helping to end the scourge of homelessness amongst America's veterans. This common-sense legislation would not increase Federal spending, rather it would simply allow State Veterans Homes to compete for existing VA grants just as private community organizations presently do.

Mr. Chairman, on behalf of the National Association of State Veterans Homes, I am pleased to offer our strong support for this legislation and respectfully request that this Committee favorably consider and report this legislation to the full Senate for its approval. This concludes my testimony. I would be pleased to respond to any questions you or Members of the Committee may have.

PREPARED STATEMENT OF THE NATIONAL BOARD FOR CERTIFIED COUNSELORS, INC.



STATEMENT OF

DAVID BERGMAN, J.D.
VICE PRESIDENT OF LEGAL AND EXTERNAL AFFAIRS
CHIEF LEGAL OFFICER
NATIONAL BOARD FOR CERTIFIED COUNSELORS, INC. AND AFFILIATES

FOR THE RECORD

VETERANS' AFFAIRS COMMITTEE
UNITED STATES SENATE

WITH RESPECT TO

Hearing: Pending Health and Benefits Legislation

WASHINGTON, D.C.

October 30, 2013

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am writing on behalf of the National Board for Certified Counselors (NBCC) in support of S. 1155, the Rural Veterans Mental Health Care Improvement Act. NBCC is the national credentialing organization for the counseling profession, representing over 52,000 National Certified Counselors (NCCs) in the United States. NBCC also develops and administers the examinations for licensure of mental health counselors in all fifty states, Puerto Rico, and the District of Columbia.

NBCC believes that the path to improved mental health service delivery in the Department of Veterans Affairs (VA) is through increased access to qualified mental health counselors. Provider shortage is often cited as a cause for service restrictions and delays, particularly in rural and underserved areas. To increase access, the VA needs to ensure an adequate supply of mental health professionals, including mental health counselors.

Mental health counselors are licensed in all fifty states to provide clinical mental health services to individuals, families and groups. They practice independently in all behavioral health settings, including private and group practice, community health centers, hospitals and educational and government institutions. Mental health counselors provide diagnosis and treatment of mental and addictions disorders, psychotherapy, counseling, and other services offered by all mental health professionals, such as clinical social workers and psychologists. There are over 128,000 licensed mental health counselors in the United States, comprising over 23% of the mental health workforce. The number of counseling students in accredited programs exceeds 38,000, and the Bureau of Labor Statistics predicts a 36% increase in counselor employment between 2010 and 2020, which is twice the average rate for all professions.

Mental health counselors play a key role in the mental health delivery system and are expected to play a greater role in the future. Mental health counselors are qualified and available to address the workforce shortages confronting the VA. Congress passed legislation in 2006 authorizing the employment of mental health counselors to provide services within the VA. In September 2010, qualification standards were released that established the policies necessary to begin hiring Licensed Professional Mental Health Counselors (LPMHCs). According to staffing data provided by the VA, only 29 LPMHCs were employed through August 2012. Of those, only nine were employed during the VA hiring initiative that began in May 2012. The employment of only nine LPMHCs among a new workforce of 2,900 demonstrates that more needs to be done.

S. 1155, the Rural Veterans Mental Health Care Improvement Act, increases access to Licensed Professional Mental Health Counselors (LPMHCs) and strengthens mental health services for rural veterans and their families. The bill increases the availability of mental health professionals who are trained to treat our veterans by expanding the Health Professional Trainee Program to include Licensed Professional Mental Health Counselors (LPMHCs) and Marriage and Family Therapists (MFTs). This program is the flagship recruitment program for health professionals in the VA, through which most psychologists and social workers are hired. The VA has provided no legitimate rationale for extending the program to social workers, psychologists, and psychiatric nurses, but not LPMHCs or MFTs. In order to ensure the broadest pool of qualified mental health professionals, this legislation directs the VA Office of Academic Affiliations (OAA) to allow LPMHCs and MFTs to participate in the trainee program.

The Rural Veterans Mental Health Care Improvement Act provides additional services to rural veterans and their families that are critically important. It offers greater flexibility to spend information technology funds; strengthens mental health services for the families of veterans; and sets the foundation for increasing the use of telemedicine by identifying barriers to usage.

NBCC applauds Senator Tester for introducing S. 1155. Veterans and their families cannot afford to wait for increased access to mental health services. Thank you for your consideration and please feel free to contact David Bergman at 703-739-6208 / Bergman@nbcc.org with any questions.

PREPARED STATEMENT OF THE NATIONAL COALITION FOR HOMELESS VETERANS



Statement for the Record of the

National Coalition
for Homeless Veterans

**United States Senate
Committee on Veterans' Affairs**

Hearing on

Pending Health Care and Benefits Legislation

October 30, 2013

Chairman Bernie Sanders, Ranking Member Richard Burr, and distinguished members of the Senate Committee on Veterans' Affairs:

The National Coalition for Homeless Veterans (NCHV) is honored to present this Statement for the Record for the legislative hearing on October 30, 2013. On behalf of the 2,100 community- and faith-based organizations NCHV represents, we thank you for your commitment to serving our nation's most vulnerable heroes.

This written statement will reflect NCHV's support for ending veteran homelessness and the three bills presented at the hearing today that have the potential to most strongly impact that goal. If passed into law the following three bills would strengthen the efforts of our community toward providing safe, effective, and wide ranging programs of relief for homeless and at-risk veterans:

- **S. 1540**, Sen. Sherrod Brown's "a bill to amend title 38, United States Code, to include contracts and grants for residential care for veterans in the exception to the requirement that the Federal Government recover a portion of the value of certain projects."
- **S. 1580**, Sen. Mark Begich's "Ensuring Safe Shelter for Homeless Veterans Act."
- **S. 1593**, Sen. Jack Reed's "Servicemember Housing Protection Act."

S. 1540, "a bill to amend title 38, United States Code, to include contracts and grants for residential care for veterans in the exception to the requirement that the Federal Government recover a portion of the value of certain projects."

This bill would alter the recapture provision that allows the Secretary of the Department of Veterans Affairs (VA) to recover disbursed grant monies in the event that the building for which that money was disbursed ceases to function in the agreed upon way. The alteration proposed in S. 1540 would add residential care to the list of exemptions under which the Secretary may not employ the recapture provision.

Altering the recapture provision in this way would be ease the way for existing VA-associated facilities to add residential care programs for homeless veterans. Two such programs provide critical health care to homeless veterans: Health Care for Homeless Veterans (HCHV), and Domiciliary Care for Homeless Veterans (DCHV). Between them, these two programs provide a wide range of services and short-term housing to homeless veterans on the grounds of VA medical facilities or in the nearby community.

HCHV was the first homeless veterans program, and since its establishment in 1987 it has been extended to 135 sites. In 2011 it was utilized by 88,905 veterans in need of health care. HCHV provides same-day access to temporary housing and health care, including mental health care. Because the homeless population does not regularly (if at all) have access to preventative health care, this is often the only source of medical services available to them.

DCHV provides rehabilitative services in a residential setting. These rehabilitative services are for those who need lesser levels of care than those offered in hospitals or nursing homes, but who still need assistance in overcoming the impacts of illness or serious injury through medical,

psychological, vocational, educational and social services. DCHV has expanded to 44 sites across the country, consisting of 2,300 beds. These beds serve 8,000 homeless veterans a year.

These programs are vital to the campaign to end veteran homelessness and they are efficacious. The proposed change in the recapture provision would ease their expansion to more facilities across the country, and NCHV supports emplacing these programs in as many communities as have the need.

S. 1580, "Ensuring Safe Shelter for Homeless Veterans Act"

Grant Per Diem (GPD) programs are the front lines of the fight against extant veteran homelessness. Theirs is the "rescue" mission – to immediately house homeless veterans and stabilize them for advancement to permanent housing. The safety of these veterans and the staffs of these facilities should be a top priority. For this reason, NCHV supports the strengthening of existing safety code inspection procedures.

By mandating that code verifications take place on a yearly basis, this bill provides for the constant compliance with the Life Safety Code of the National Fire Protection Association – long the standard to which GPD programs have been held.

Furthermore, NCHV feels that the necessary addition of the ability for the Secretary to revoke certifications is balanced by the lenient period of time in which current grantees must come into compliance. Providing the Secretary with the ability to revoke certifications creates a mechanism to ensure that the letter of the law is followed. The two-year period for compliance before stoppage of per diem payments allows grantees to make necessary changes in their buildings in a reasonable amount of time.

In general, NCHV feels that this is a measured and effective approach to ensuring the safety of our homeless veterans and grantee staff members, without placing an undue burden on those same grantees. Our only reservation is with the revocation clause found in section 2, subsection (c) of this bill. We would prefer that the section inserted as the new paragraph (2) be clarified to identify the specific causes for revocation of certifications.

S. 1593, "Servicemember Housing Protection Act"

The Reed bill makes an addition to the Servicemembers Civil Relief Act, and provides for one year of legal protection to surviving spouses of service members killed in action. NCHV views one-year stays of foreclosure as a preventative measure against episodes of homelessness.

Episodes of homelessness can be tied to periods of emotional and financial turbulence. These problems are often experienced by families during overseas deployments, and are horribly exacerbated when the deployed service member is killed in action.

Any protection that can be given to the families of deceased service members would provide opportunities for those families to address their financial and personal affairs without the fear of falling into homelessness. Giving families time to transition to other housing, or to address the sudden, destabilizing stressors that accompany the loss of a loved one, would go a long way toward reducing their risk of becoming homeless.

As we reach the end of the administration's Five-Year Plan to End Veteran Homelessness in 2015, prevention will become an increasingly important front in combating homelessness among veterans. We believe these bills would provide additional protections for this vulnerable population and help to prevent many of them from ever experiencing an episode of homelessness.

We sincerely thank you for your consideration, and for your service.

John Driscoll
President and CEO

National Coalition for Homeless Veterans
333 ½ Pennsylvania Ave SE
Washington, DC 20003
202-546-1969

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

Chairman Sanders, Ranking Member Burr, and Members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Committee. These important bills will help ensure that veterans receive timely, quality health care and benefits services.

S. 875, THE "DEPARTMENT OF VETERANS AFFAIRS DISEASE REPORTING AND OVERSIGHT ACT"

PVA supports S. 875, a bill to amend title 38, United States Code, to require the reporting of cases of infectious diseases at facilities of the Veterans Health Administration. The VA is a national leader in the public health sector with high standards for both quality care and patient safety. S. 875 will only augment such standards and increase the national standard for patient safety, as well as allow for accountability when the unfortunate incidence of infectious disease is reported.

S. 1148, THE "VETERANS BENEFITS CLAIMS FASTER FILING ACT"

PVA supports S. 1148, the "Veterans Benefits Claims Faster Filing Act." This legislation will ensure that veterans have access to greater information when submitting a claim. Providing information on average wait times for claims processing and the percentage of claims approved will increase the understanding of the process and may help set expectations of how long a veteran may have to wait for a claim to be adjudicated.

S. 1155, THE "RURAL VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT"

The "Rural Veterans Mental Health Care Improvement Act," proposes to provide advance appropriations for information technology accounts of the VA, include mental health professionals (marriage and family therapists and mental health counselors) in VA training programs, expand mental health services for families of veterans, and require VA to provide Congress with a report on its telemedicine services.

PVA understands the positive impact that advance appropriations of VA medical Care accounts has had on the delivery of health care services to veterans in the most recent budget cycles, and therefore, supports the general intent of this particular provision. However, we believe that the Committee should not focus only on

accounts for health related information technology, but rather, VA should be given the authority to provide advance appropriations for all discretionary accounts. Therefore, we ask that the Committee consider S. 932, the “Putting Veterans Funding First Act of 2013,” which proposes to amend title 38 to provide advance appropriations for VA discretionary accounts.

The second provision of this bill proposes inclusion of mental health professionals in VA’s education and training program for health personnel. As this program was created to enhance VHA services and ensure that an adequate supply of health personnel is available in the medical field, PVA believes that specific positions such as marriage and family therapists, and licensed professional mental health counselors should be added based on the need identified by the VA.

Last, PVA fully supports the provisions of this bill that would expand mental health services for families of veterans at VA Centers for Readjustment Counseling, and require VA to report on specific aspects of its telemedicine services.

S. 1165, THE “ACCESS TO APPROPRIATE IMMUNIZATIONS FOR VETERANS ACT”

PVA supports S. 1165, which proposes to amend title 38, United States Code to provide for requirements related to the immunization of veterans. It is accepted fact that proper and timely administration of immunizations can prevent the onset of more significant medical issues. By ensuring that immunizations are administered in compliance with the recommended adult immunization schedule, it can be expected that veterans using the VA will be healthier and less likely to suffer potential medical ailments. Proper and timely immunizations are a guarantee of better medical health in the VA patient population.

S. 1211

PVA supports S. 1211. As veterans make plans for their future and make decisions on continuing their education or seek further technical training they need facts pertaining to institutions and training programs. The information needed would be facts such as how many veterans attend a school or program, how many veterans complete the program, what supports are available for veterans enrolled in a program, and how many veterans find employment in that field after completing or graduating from a program. This information is often not available as veterans make decisions for their future. Unfortunately the number of new schools and training programs aimed at veterans has burgeoned specifically as a result of the Post-9/11 GI Bill. Organizations that resort to using “Post-9/11 GI Bill” or “GI Bill” in their promotion most likely are among organizations that intend to mislead veterans. PVA supports this legislation that would prohibit the use of any reference to this earned veterans’ benefit in advertising or promotions.

S. 1216, THE “IMPROVING JOB OPPORTUNITIES FOR VETERANS ACT”

PVA supports S. 1216, the “Improving Job Opportunities for Veterans Act of 2013,” which assures certain requirements for career training programs for veterans. This legislation would require, for a four-year period, that training establishments that apply for state approval of on-the-job training programs must certify that the wages to be paid to the eligible veteran or person upon entrance into training will be increased in regular periodic increments. By the last full month of the training period, wages paid to the veteran will be at least 75 percent (currently 85 percent) of the wages paid for the job for which the eligible veteran or person is being trained. This reduces the financial responsibility for employers by 10 percent. Hopefully this reduction for the employer, with the financial difference being paid by the VA, will be an incentive for employers to participate.

The legislation also extends from November 30 through December 31, 2016, the requirement of a reduced pension (\$90 per month) for veterans (with neither spouse nor child) or surviving spouses (with no child) covered by Medicaid plans under title XIX of the Social Security Act for services furnished by nursing facilities.

This legislation also directs the VA to enter into agreements with other Federal agencies to operate similar on-the-job training programs for eligible veterans to perform skills necessary for employment by the department or agency operating the program. This initiative would be an excellent program to ensure that the men and women that served their country will be trained and prepared to continue serving their country.

While this bill has great potential to improve job opportunities for veterans, we do have concerns about accountability of the program. Specifically, how will the provisions outlined in the bill be enforced? How will the Federal agencies involved in this program be evaluated? Moreover, what will be the penalty for agencies that do not embrace this program? This program could help thousands of veterans establish

careers in the Federal Government if it is presented as a requirement, firmly backed by the Administration, and closely monitored.

S. 1262, THE "VETERANS CONSERVATION CORPS ACT"

PVA supports S. 1262, the "Veterans Conservation Corps Act of 2013." This legislation requires the VA to coordinate and develop agreements with other Federal programs including the Department of Justice, Department of Agriculture, Department of Commerce, Department of Interior, Homeland Security, and the Chief of Engineers, to establish a Veterans Conservation Corps. This program will provide training and employment opportunities to help veterans in the transition from military service to civilian life. Veterans who participate in this Conservation Corp program will perform work in Conservation, Resource Management, and Historic Preservation Projects on public lands and maintenance and improvement projects for cemeteries under the jurisdiction of the National Cemetery Administration.

Similar agreements with other agencies will be established allowing veterans to learn from and perform in positions such as firefighters, law enforcement officers, and disaster relief personnel. These Federal agencies will employ veterans to perform these functions within their agencies, or award grants to, or contracts with, state governments, local governments, or nongovernmental entities to employ veterans to perform work in these areas.

PVA does not support the section that specifies that a priority for the employment of veterans shall be given to those veterans who served on active duty in the Armed Forces on or after September 11, 2001. We believe any unemployed veteran that honorably served who needs and deserves a job should be afforded an equal opportunity.

PVA supports most of this effort to provide veterans with the opportunity to continue to serve in various capacities throughout their communities. However, this program will require extensive oversight by the VA and Congress. Requiring Federal agencies to develop, adapt, and embrace additional responsibility is always met with resistance.

S. 1281, THE "VETERANS AND SERVICEMEMBERS EMPLOYMENT RIGHTS AND HOUSING ACT"

PVA supports S. 1281, the "Veterans and Servicemembers Employment Rights and Housing Act of 2013." This legislation prohibits employment practices that discriminate based on an individual's military service and amends the "Fair Housing Act" and the "Civil Rights Act of 1968" to prohibit housing discrimination against members of the uniformed services. The legislation will protect veterans against employers who fail to hire, discharge, or otherwise discriminate against veterans because of their military service. It also prohibits employers, employment agencies, labor organizations, and job training programs from engaging in specified practices that adversely affect an applicant or employee because of military service. Ultimately, PVA supports the concept of adding military veterans as a category or group into certain Federal laws that currently prohibit discrimination based on a particular category or group of individuals.

S. 1295

PVA strongly supports S. 1295 to require the Secretary of Veterans Affairs to provide veterans with notice, when veterans electronically file claims for benefits that relevant services may be available from veterans service organizations. One of PVA's main goals and mission objectives is to help veterans receive the benefits they so richly deserve. PVA, like other Veterans Service Organizations, has established a network of Service Officers across the country for this specific purpose. The VA claims process can be challenging and laborious for those who do not understand it. This is particularly true for those with catastrophic injuries or complex claims. While VA does a good job of providing information about the availability of VSO support to veterans wanting to file a claim, requiring this in any electronic filing program VA may create will be a guarantee that this information is provided to veterans and not overlooked by a software programmer.

S. 1296, THE "SERVICEMEMBERS' ELECTRONIC HEALTH RECORDS ACT"

PVA generally supports S. 1296, a bill to create a specific timeline for the VA and the Department of Defense (DOD) to achieve interoperable electronic health records. PVA believes that VA and DOD must remain committed to completing an electronic health record that is fully interoperable, and allows for a two-way electronic exchange of information that is accessible and can be computed by medical profes-

sionals. This bill will require both VA and DOD to engage in continuous dialog to determine the best means for information exchange, as well as discuss the feasibility of creating a data storage system to improve accessibility of patient health records and data. While this bill does not address the issues that have prevented the implementation of a fully interoperable electronic health records system, it does attempt to move the process forward with specific dates to assess and evaluate the current status of the initiative. As stated in the FY 2014 Independent Budget, “[PVA] remains firm that VA and DOD must complete an electronic medical record process that will help patients transition between health care settings; reduce duplicative testing, and improve patient safety.”

S. 1361, THE “WORLD WAR II MERCHANT MARINER SERVICE ACT”

While PVA recognizes the valuable service provided by the Merchant Marines during World War II, PVA has no position on S. 1361, the “World War II Merchant Mariner Service Act.”

S. 1399

PVA supports S. 1399, the “Servicemembers Student Loan Affordability Act.” This legislation would amend the Servicemembers Civil Relief Act (SCRA) to extend the interest rate limitation on debt entered into before military service and debt incurred during military service as well as to consolidate or refinance student loans incurred before military service. Loan consolidation is a practical, effective way to manage student loan debt. The consolidation of one or more student loans incurred by the servicemembers before military service shall be limited to an interest rate of 6 percent.

S. 1411, THE “RURAL VETERANS HEALTH CARE IMPROVEMENT ACT”

PVA supports S. 1411, to specify requirements for the next update of the current strategic plan for VA’s Office of Rural Health (ORH). PVA believes that attracting and retaining adequate staff within the Veterans Health Administration (VHA) is one of the most critical elements of providing quality health care in a timely manner. Recruiting and retaining medical professionals in rural settings continues to be a challenge as the population of veterans residing in rural areas continues to grow. PVA believes that the requirements of S. 1411, to include specific goals and objectives in the current ORH strategic plan has the potential to further develop and expand upon the improvements that VA has already made in the area of rural health care. Particularly, PVA is pleased that this bill requires VA leadership to define specific goals and objectives in the areas of recruitment and retention, and enhance the use of current programs using technology to increase veterans’ access to VA health care services.

This bill also requires the VA ORH to “refresh” the strategic plan so that it includes goals and objectives for ensuring timeliness and improving the quality of health care services provided through contract and fee-basis providers. PVA believes that non-VA providers serve a purpose in meeting the health care needs of veterans residing in rural areas and are an essential component of the VA providing timely care in remote settings. However, such options should not be used as a method or course to eliminate VA facilities. PVA believes that the greatest need is still for qualified VA health care providers to be located in rural areas. We believe that the VA is the best health care provider for veterans. Providing primary care and specialized health services is an integral component of VA’s core mission and responsibility to veterans.

S. 1434

PVA’s National office has no position on naming the Junction City, Kansas, community-based outpatient clinic after Lieutenant General Richard J. Seitz. PVA believes naming issues should be considered by the local community with input from veterans organizations within that community. With that in mind, we would defer to the views of PVA’s Mid-America Chapter.

S. 1471, THE “ALICIA DAWN KOEHL RESPECT FOR NATIONAL CEMETERIES ACT”

PVA has no specific position on this proposed legislation. However, we do have some concerns as it relates to the provisions and application of this legislation, were it to be enacted. This is an issue that goes to the heart of the rules and rationale for the granting and, in some most unfortunate circumstances, taking away of benefits and entitlements conferred on this Nation’s defenders by a grateful Nation. While we are certainly sympathetic to the families impacted by situations such as

those of the namesake of this legislation, we believe this proposal oversteps the boundary for determination of interment in a national cemetery.

Specifically, we believe this legislation plays to the emotional nature of capital crimes at the expense of due process. The legislation would authorize possible disinterment of remains of veterans without them having actually being convicted of a crime. The language negates the concept of “innocent until proven guilty” by suggesting that a veteran “may have been convicted” of a Federal or state capital crime. What is the burden of proof for “may have been convicted?” Congress passed Public Law 105–116 in 1997 prohibiting people convicted of Federal or state capital crimes and sentenced to death or life imprisonment without parole from being interred at Arlington and other national cemeteries. However, this legislation never reaches that standard for determination for burial eligibility. It simply presumes guilt to meet the threshold for denial of burial.

Generally, veterans tend to expect more from veterans, to hold ourselves to a higher standard of behavior. Yet we must also realize that, just as in other segments of society, individuals will violate the rule of law and do unjustified harm to others. Under these circumstances justice must be met out, and all appropriate punishment under law applied. When Public Law 105–116 was considered, it was the collective conclusion of most veterans’ service organizations that permitting individuals so undeserving of such honor to be buried in veteran’s cemeteries would diminish the dignity and service of other veterans and their survivors who are fully deserving of the honor. However, the post-military actions of individuals are not generally the basis for consideration of eligibility for interment in a national cemetery. And when those actions have not been adjudicated as criminal in a court of law, we do not believe that the standard has been met to prevent interment or disinter veterans who had been previously honorably discharged from military service and otherwise met the eligibility criteria.

S. 1540

PVA does not have an official position on S. 1540, a bill to amend title 38, United States Code to include contracts and grants for residential care for veterans as part of an exception to the requirement that the Federal Government recover a portion of the value of certain projects.

S. 1547, THE “VETERANS DIALYSIS PILOT PROGRAM REVIEW ACT”

PVA supports S. 1547, the “Veterans Dialysis Pilot Program Review Act of 2013.” If enacted, S. 1547, the “Veterans Dialysis Pilot Program Review Act of 2013,” would require VA to review its current dialysis pilot program and submit a report to Congress before expanding the program. In 2012, the Government Accountability Office (GAO) published a report titled, “VA Dialysis Pilot: Increased Attention to Planning, Implementation, and Performance Measurement Needed to Help Achieve Goals.” In the report many weaknesses with the pilot were cited, as well as recommendations to improve the pilot.

S. 1547 would require VA to respond to these recommendations, as well as prevent expansion of the program until the pilot has been implemented for two years at each initial site. Gathering and analyzing data to make the most informed decisions is always best when such choices involve veterans’ health care. As GAO has identified issues and made recommendations regarding the Veterans Dialysis Pilot Program, the VA should be required to provide Congress with current program updates to such recommendations, as well as findings from any additional analysis of the program. Many of the requirements established in this bill are similar to the recommendations from the GAO report, with which the VA concurred.

S. 1556

S. 1556, is a bill to amend title 38, United States Code, to modify authorities relating to the collective bargaining of employees in the Veterans Health Administration (VHA). PVA has serious concerns regarding this bill and its potential to negatively impact VA patient care.

Title 38, section 7422, “Collective Bargaining” states:

“* * * (b) [Collective bargaining] may not cover, or have any applicability to, any matter or question concerning or arising out of (1) professional conduct or competence, (2) peer review, or (3) the establishment, determination, or adjustment of employee compensation under this title.

(c) For purposes of this section, the term “professional conduct or competence” means any of the following:

- (1) Direct patient care.
- (2) Clinical competence

(d) An issue of whether a matter or question concerns or arises out of (1) professional conduct or competence, (2) peer review, or (3) the establishment, determination, or adjustment of employee compensation under this title shall be decided by the Secretary and is not itself subject to collective bargaining and may not be reviewed by any other agency.”¹

S. 1556 proposes to eliminate subsections (b), (c), and (d). While PVA supports improving the collective bargaining rights and procedures for review of adverse actions for VHA health care professionals, it is our position that such bargaining rights should not interfere with direct patient care and delivery of VA health care services. PVA fully understands the invaluable commitment and service that VA medical professionals provide to the Nation’s veterans. They are the backbone of the VHA system and should be afforded certain rights that ensure a safe and productive work environment. As such, we strongly urge VA leadership and union representatives to work together to identify legislative and policy outcomes that will improve the collective bargaining rights and procedures of VHA without impacting the direct delivery of patient care, or amending title 38 as proposed by this bill.

S. 1558, THE “VETERANS OUTREACH ENHANCEMENT ACT”

A common theme of many individuals who have testified before the Senate and House Committees on Veterans’ Affairs in the past has been that many service-members returning to the civilian world often have limited, or no knowledge of the programs, benefits, and assistance available for them based on their active military service. This legislation, S. 1558, the “Veterans Outreach Enhancement Act” will help communicate the wide array of information to all veterans, including veterans in rural areas. This legislation authorizes the Secretary to develop and carry out a program of outreach which may include collaborating with state and local governments to help perform this outreach.

However, PVA has a concern that the VA may designate portions of this outreach responsibility to the states through each states’ Local Veterans’ Employment Representatives (LVER) and Disabled Veterans’ Outreach Program (DVOP) specialists. Although some states may excel at helping veterans through these federally funded programs, traditionally these programs do not fulfill the responsibilities of placing veterans in employment, or informing veterans of benefits. Therefore, PVA believes allocating more funds to individual states through these programs will not increase the VA’s outreach efforts. Most states have a Department of Veterans Affairs. Like the state employment programs, these vary widely in their responsibilities and performance. For the VA to designate and rely on these offices to fulfill the VA’s outreach responsibilities will require extensive oversight of these offices.

S. 1559, THE “BENEFITS FAIRNESS FOR FILIPINO VETERANS ACT”

PVA has no official position on S. 1559, the “Benefits Fairness for Filipino Veterans Act of 2013.” That being said, we do not see a need for legislation that would essentially alter the definition of residency for veterans in the United States.

S. 1573, THE “MILITARY FAMILY RELIEF ACT”

PVA supports S. 1573 to provide payment of temporary compensation to a surviving spouse of a veteran upon the veteran’s death. The difficult transition period for the family following the death of a loved one is often confused and challenging. The ability of a spouse to care for herself and her affairs can be made very difficult when their veteran’s partner passes away. This is particularly true if the spouse had served as the primary caregiver, as is often the case for veterans with service-connected disabilities continuously rated as total. Even if a new widow had filed a claim for DIC or pension, the time to process this can be lengthy. There are also reports that this compensation is sometimes incorrectly denied at the VA Regional Office and needs to go to an appeal before being approved. Providing temporary compensation for a period not to exceed six months allows for an appropriate period of transition and it is also our understanding that VA supports this legislation.

¹ Title 38, United States Code, Section 7422.

DRAFT BILL ON SERVICE-DISABLED INSURANCE PROGRAM

PVA generally supports this legislation that would make the needed adjustment to update premium rates based on the most recent mortality table for Service-Disabled Veterans Insurance. The service-disabled veterans' life insurance began in 1951 using mortality information from 1941, information that is clearly outdated when compared to mortality rates of the current population. Using inaccurate mortality rates results in premiums that are more costly for veterans. Updated mortality tables and rates should ultimately lead to a reduction in premium rates for veterans.

DRAFT BILL ON REPLACEMENT AUTOMOBILES FOR CERTAIN DISABLED VETERANS

PVA supports the proposed legislation that would improve the adaptive automobile assistance grant. This issue has been a high priority for PVA since our founding in 1946. For many PVA members, the automobile (or converted van) is the only viable transportation for their daily activities whether for employment, medical appointments, family needs, or other activities of everyday living. As explained in *The Independent Budget (IB)* for FY 2014, the cost to replace a modified vehicle in the current market is \$40,000 to \$65,000. The *IB* also quotes the Department of Transportation's report documenting the life span for a vehicle of 12 years, or 128,500 miles. This legislation would significantly increase the value of the grant to \$30,000 and further relieve the financial burden associated with the purchase of an adapted vehicle.

This legislation also allows a veteran to use the grant up to three times until reaching the maximum dollar amount. PVA strongly recommends that this provision not include a delimiting date so as to be applicable to all veterans who have qualified for the grant. As an aside, PVA would recommend that the Committee evaluate the effectiveness of allowing veterans to use their Specially Adapted Housing (SAH) grant up to three times (a provision that was enacted into law several years ago) as a basis for comparison in understanding the potential for allowing a similar benefit with the automobile assistance grant.

THE "VETERANS HEALTH CARE ELIGIBILITY EXPANSION AND ENHANCEMENT ACT"

The "Veterans Health Care Eligibility Expansion and Enhancement Act of 2013," proposes to amend title 38, United States Code, to expand and enhance eligibility for VA health care services. PVA does not support Section 2 of this bill, titled, "Enhancement of Nature of Eligibility for Care of Veterans." Specifically, this section proposes to amend title 38, United States Code, by mandating that the VA "shall" furnish nursing home care to non-compensable and non-service-connected veterans with a disability rating of 50 percent or more. With this change the VA would not have the same mandate to provide such care to compensable service-connected disabled veterans rated less than 50 percent. The proposed change in this section is inequitable and in direct opposition to the purpose of the VA's disability rating system.

PVA supports Sections 3 and 4 of this bill which includes opening enrollment to uninsured veterans not currently eligible to receive VA health care services and extending the period of eligibility for health care for veterans of combat service. PVA appreciates that this bill attempts to increase veterans' access to VA health care services, especially long-term care services. Particularly, we support Section 3, to open enrollment for veterans that are legally eligible for VA health care, but not eligible to enroll at this time. PVA believes that this is most appropriate given the national coverage mandate from the "Patient Protection and Affordable care Act." We encourage the Committee to enact all of the aforementioned provisions and provide the resources as needed to account for any increase in utilization and demand for services.

THE "ENHANCED DENTAL CARE FOR VETERANS ACT"

PVA generally supports the provisions of the "Enhanced Dental Care for Veterans Act." That being said, we have some concern about the potentially high cost that his proposal could have on the VA. Dental services are generally not cheap. Such a potential broad-based expansion could significantly increase the overall cost to provide health care for the VA. With this in mind, it will be incumbent upon Congress to ensure that sufficient resources over and above what are currently provided are made available to carry out both the pilot program that is proposed and any additional expansion that may come as a result of the pilot program.

THE “MENTAL HEALTH SUPPORT FOR VETERAN FAMILIES AND CAREGIVERS ACT”

PVA supports the “Mental Health Support for Veteran Families and Caregivers Act of 2013. This legislation proposes to establish both an education program and peer support program for family members and caregivers of veterans with mental health disorders. PVA fully understands the importance of providing educational and support services to those who care for veterans with both physical disabilities and mental health disorders, as the majority of our members rely on the assistance of a family member or caregiver. The education and peer support programs will allow veterans’ family members and caregivers to become fully incorporated in their treatment plan. We ask that the Committee consider providing variations on the 10 week education program to accommodate the busy schedules of the family members and caregivers of veterans. Regardless of where and how the program is facilitated, 10 weeks may discourage individuals from enrolling in, or completing the program. Providing an option that can be completed in less time as an alternative option to the 10 week program may be more appealing to family members and caregivers who are balancing responsibilities of family, career, and caring for a veteran.

THE “MEDICAL FOSTER HOME ACT”

PVA supports the “Medical Foster Home Act of 2013, which proposes to authorize the VA to cover the costs associated with the care of veterans at medical foster homes. Too often the costs of care while at a medical foster home leave veterans financially insolvent. Codifying this authority will allow the VA to increase access to long-term care services for veterans who would otherwise be forced into more traditional means of institutional care.

THE “SURVIVORS OF MILITARY SEXUAL ASSAULT AND DOMESTIC ABUSE ACT”

PVA supports the “Survivors of Military Sexual Trauma Assault and Domestic Abuse Act of 2013. If enacted, this bill would authorize VA to provide counseling and treatment for sexual trauma to members of the Armed Forces, screen for domestic abuse, and submit reports to Congress on military sexual trauma and domestic abuse. VA has made great strides in the development and progression of quality mental health and caring for those who have survived military sexual trauma assault; therefore, it is a logical next step to make such care available to servicemembers who will likely enroll in VA health care in the near future. PVA is pleased to see that this legislation also proposes to remove the language that is gender specific and uses servicemembers’ time of service as factors when dealing with the treatment of both military sexual trauma assault and domestic violence. Care should be provided to veterans based solely on need.

DRAFT BILL ON REIMBURSEMENT FOR EMERGENCY MEDICAL TREATMENT

PVA generally supports the intent of the proposed draft bill that would eliminate the requirement that veterans be seen within the prior 24-month period when seeking reimbursement for medical treatment. However, we have real concerns about the inequity created by the legislation. While we understand the concern about veterans being seen in a timely manner when having an initial appointment with primary care providers, we do not believe that this population should receive special treatment for emergency care reimbursement simply because of the nature of when they are seeking treatment. Moreover, qualifying the concept that VA has specifically imposed a waiting period for appointments is primarily based on anecdotal evidence, not quantifiable evidence.

Additionally, this legislation seemingly discriminates against new enrollees who may choose not to have an immediate VA appointment because he or she is generally healthy. Likewise, it treats all other veterans who are otherwise enrolled in the VA differently when it comes to emergency care reimbursement. In order to be fair and equitable, this legislation should eliminate the 24-month requirement entirely.

THE “IMPROVED COMPENSATION FOR HEARING LOSS ACT”

PVA supports the proposed legislation, but cautions that reports are only a first step and are not enough. In particular, PVA thinks it is important to examine the actions by VA to implement the findings and recommendations of the 2006 Institute of Medicine report on “Noise and Military Service: Implications for Hearing Loss and Tinnitus.” Additionally, the examination of those members of the Armed Forces not included on the Duty Military Occupational Specialty Noise Exposure Listing who were precluded from receiving benefits related to hearing loss. Many aspects of the Nation’s current conflicts have had to be reevaluated as the combat environ-

ment has changed. An examination is not only prudent, but critical to caring for and compensating our veterans. This together with an explanation of the rationale for the practice of VA not issuing a compensable rating for hearing loss at certain levels that are severe enough to require the use of hearing aids is needed to understand how VA is making its determinations. Finally, while it is important to examine the problems with VA practices on providing services to veterans with hearing loss, PVA expects to see further legislation to correct any deficiencies or improper practices that are identified.

DRAFT BILL ON NATIONAL CENTER FOR TOXIC RESEARCH AND SERVICES
FOR VETERANS' DESCENDANTS

While PVA understands the underlying intent of the proposed bill, we do not support the, "Toxic Exposure Research and Military Family Support Act of 2013." This legislation proposes to select a VA medical center to serve as the national center for the diagnosis, treatment, and research of health conditions of descendants of individuals exposed to toxic substances while serving as members of the Armed Forces. We appreciate that this bill recognizes the importance of providing the descendants of veterans who have been exposed to toxic substances with quality, effective care. However, we believe that this responsibility does not rest with the VA. We believe that this requirement would be most successfully carried out if coordinated through a public health agency with a broader mission and health care focus, such as the Department of Health and Human Services, or the National Institutes of Health, with the direct support of the Department of Defense.

We believe that the provisions of this bill are outside of the VA's official mission, and entitle the descendants of veterans to services and benefits that are unavailable to even service-connected veterans enrolled in the VA health care system. We fully object to the provision of this legislation that would entitle the descendants covered by this proposal to comprehensive caregiver assistance, a benefit that is currently denied to every catastrophically disabled veteran injured prior to September 11, 2001.

Additionally, we have concerns about the proposed Advisory Committee. First, the provisions of the bill exclude organizations such as PVA, Disabled American Veterans, and other 501(c)(3) veterans service organizations from being represented on the Committee. We also question on what grounds this Advisory Committee should have subpoena authority? While we understand that such ability might improve its efforts, it has no real legal standing or grounds to punish individuals who might choose to ignore a subpoena.

PVA would once again like to thank the Committee for the opportunity to submit our views on the legislation considered today. We would be happy to answer any questions that you may have for the record.

PREPARED STATEMENT OF NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN
WARS OF THE UNITED STATES

Mr. Chairman and Members of the Committee: On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, thank you for the opportunity to provide our testimony for the record regarding pending health and benefits legislation.

S. 875, DEPARTMENT OF VETERANS AFFAIRS DISEASE REPORTING AND
OVERSIGHT ACT OF 2013

The VFW supports most provisions of this legislation which would require VISN directors to report within 24 hours the presence at a VA facility of any infectious disease that is on the list of nationally notifiable diseases published by the Council of State and Territorial Epidemiologists and the Centers of Disease Control and Prevention (CDC), or covered by a state law that requires the reporting of infectious diseases, to VA Central Office, the Director of CDC, and the state and county in which the facility is located. For each individual who has contracted or is at risk of contracting a notifiable infectious disease at a VA facility, the VISN director would be required to notify the individual and the individual's next of kin, the individual's primary health care provider, the county in which the individual resides, and each employee of the VA facility. The VISN director would then be required to confirm the receipt of each notification within 24 hours and develop and implement a plan of action to prevent the spread of the infectious disease within seven days and maintain a record of infectious disease reports for at least 10 years.

Timely disease reporting is critical in detecting, controlling, and preventing the spread of communicable disease, and is a widely accepted norm of sound public health practice. Since the laws which create disease reporting requirements are established by individual state legislatures, they do not apply to Federal entities, including VA. Although individual facilities may have disease reporting policies, they lack statutory guidance across the department can lead to dangerous outcomes, as seen by the recent outbreak of Legionnaires' disease within the VA Pittsburgh Healthcare System (VAPHS) which resulted in the preventable deaths of at least five veterans and the infection of as many as 16 others. Subsequent reports by OIG and CDC found that the failure by VAPHS to properly address the outbreak in a timely manner contributed greatly to the spread of the disease. Had more stringent disease reporting protocols been in place, this terrible tragedy may have been averted. The VFW strongly supports the provisions of this legislation which would strengthen VA standards in reacting to infectious disease outbreaks and mandate that VISNs report instances notifiable infectious disease to Federal, state, and local authorities.

The only provision of this legislation that the VFW does not support is the requirement that the Secretary suspend any VISN director who is found by OIG to have failed to comply with disease reporting requirements. While we recognize the necessity for accountability, we feel that VA must be allowed to retain ultimate authority over how punishments are applied in each unique situation. To allow the results of OIG reports to determine which employees are to be punished would essentially grant enforcement power to OIG, undermining the authority of the Secretary. For this reason, we suggest that paragraph (2) of subsection (f) Enforcement and Disciplinary Action should be changed by striking "suspend" and adding "take disciplinary action up to and including the suspension of." Such a change would allow the VFW to offer its full support to this legislation.

S. 1148, VETERANS BENEFITS CLAIMS FASTER FILING ACT

This legislation would require VA to provide public notification and notice to applicants submitting for a claim for benefits of the average times for processing claims. The intent of this bill would be to show the benefits of filing fully developed, electronic claims.

The issue that arises from this that each claim that is filed under the methods described in Section 2, paragraph (c)(2) is unique to itself and factors outside of the method used to file will have an impact on the length of time it will take to properly adjudicate the claim. Stating the average time to adjudicate a claim under a certain method will set an expectation for the veteran that may not be realistic, and it may put pressure on claims processors to adjudicate claims quickly, regardless of quality. Instead of stating the average time it takes to complete a claim using a particular method, it might be more accurate and realistic to state a claim that is filed using a particular method is completed, on average, so many days faster. This will help manage veterans expectation and remove arbitrary dates that will put undue pressure on claims processors that will lead to inaccurate decisions and increased appeals by veterans.

Also, amendments are needed to improve the accuracy of Section 2, paragraph (b)(2) and Section 2, paragraph (c)(B). Paragraph (b)(2) would need to be amended to clarify the language that only original claims may qualify for the extra year of benefit payment. Paragraph (b)(2) would need to be amended to change "durable power of attorney" to "limited power of attorney."

S. 1155, RURAL VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT

The VFW supports this legislation which contains several provisions that improve the quality of mental health services for rural veterans. By providing advance appropriations for VA Information Technology (IT) Systems account, this legislation would ensure that VA care is delivered without any disruption to the replacement of medical equipment or the functioning of information systems. The VFW supports this provision, strongly believing that all VA accounts should receive advance appropriations.

This legislation would also include licensed mental health counselors and marriage and family therapists for participation in the VA Health Professionals Trainee Program, which is used as qualifying training to hire mental health care providers to work within VA. The VFW is hopeful that the recently signed Patient-Centered Community Care (PCCC) contracts will provide the needed specialty health care providers in these rural and remote locations. The VFW recommends waiting for full implementation of PCCC and evaluating remaining gaps in care before expanding

the eligibility for participation in the VA Health Professionals Trainee Program. Any program expiration must not reduce the quality of care that is delivered.

The VFW also supports the provision of this legislation which would strengthen the language in current law providing mental health services to family members of Post-9/11 veterans. Finally, this legislation requires VA to submit a report to Congress describing any factors which are impeding the expansion of telehealth services. The VFW believes that telehealth has great potential to improve access to VA programs and services for rural veterans, and any barriers to its expansion must be identified and overcome.

S. 1165, ACCESS TO APPROPRIATE IMMUNIZATIONS FOR VETERANS ACT OF 2013

The VFW strongly supports this legislation which contains two important health-related enhancements for veterans. The bill would ensure that veterans receive the full complement of immunizations on the recommended adult immunization schedule established by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP). It would also mandate that VA develop and implement quality measures and metrics to ensure that veterans receiving VA medical services receive each immunization at the proper time according to the ACIP.

As many as 70,000 American adults die each year in from vaccine-preventable diseases. In 2008, CDC estimated that the number of deaths among adults that could be prevented by vaccination is greater than the number of deaths caused by breast cancer, colorectal cancer or prostate cancer combined. The VFW believes the evidence is clear that vaccination is one of the safest, most cost effective ways to prevent disease and death from infectious diseases.

Efforts to quantify and track vaccine utilizations in the past have clearly shown that prioritizing increased utilization and effectiveness of vaccination inoculations, in tandem with rigorous performance measures, generate monumental savings while improving patient health. When VA adopted performance measures for influenza and pneumococcal, significant improvement in vaccine utilization rates resulted—from 27 percent to 77 percent and 26 percent to 80 percent, respectively. Expanding performance measures to the entire list of VA and CDC recommended adult vaccinations would undoubtedly promote timely and appropriate vaccinations while placing a greater emphasis on preventable care for veterans.

S. 1211, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO PROHIBIT THE USE OF THE PHRASES GI BILL AND POST-9/11 GI BILL TO GIVE A FALSE IMPRESSION OF APPROVAL OR ENDORSEMENT BY THE DEPARTMENT OF VETERANS AFFAIRS.

In 2011, the VFW signed on to a letter to the White House calling on VA to trademark the phrase “GI Bill.” Through the VFW’s advocacy, this recommendation was included in Executive Order No. 13607, which improved consumer resources for student veterans. The VFW agrees in principle with Sen. Boxer on this legislation, which seeks to ensure that veterans cannot be duped by bad actors in higher education by misrepresenting themselves as a VA-associated entity or a GI Bill-sanctioned institution or informational tool. However, we believe that this legislation is unnecessary since VA successfully trademarked GI Bill in 2012.

S. 1216, IMPROVING JOB OPPORTUNITIES FOR VETERANS ACT OF 2013

The VFW supports Sen. Bennett’s legislation to modify VA’s on-the-job training (OJT) program in a manner that will encourage more companies to participate by lowering the out-of-pocket cost to the employer during the training program. College is not for everyone, which is why the VFW has long supported OJT as an option for GI Bill-eligible veterans. OJT programs offer veterans an opportunity to acquire critical skills that prepare them to compete in the civilian workforce when they do not wish to pursue a college degree program. Sadly, OJT is vastly underutilized and some companies believe that they do not have enough incentive to participate, because of potential costs to the company. The VFW encourages the Senate to pass this legislation, which when coupled with an awareness campaign on VA OJT could significantly improve real world training opportunities for veterans.

S. 1262, VETERANS CONSERVATION CORPS ACT OF 2013

The VFW has long supported the concept of the Veterans’ Conservation Corps. In 2010, the VFW supported the concept as part of a broader veterans’ employment initiative before this Committee and last year we expressed our support for stand-alone legislation, which is why we are proud to support Sen. Nelson once again. We believe that a conservation corps will offer unique opportunities to veterans who do

not participate in other Federal training programs to work preserving national parks, monuments and other infrastructure projects.

Veterans were hit disproportionately hard by the recent recession, and the latest employment figures for the Bureau of Labor Statistics indicate that Iraq and Afghanistan-era veterans still struggle at finding employment when compared to their civilian peers. The conservation corps is just one more step to help veterans get back to work and acquire the kinds of skills that will make them competitive in the job market. This model succeeded for past generations of veterans and we believe it could succeed again.

S. 1281, VETERANS AND SERVICEMEMBERS EMPLOYMENT AND HOUSING
RIGHTS ACT OF 2013

The VFW supports Sen. Blumenthal's legislation that will ensure veterans are offered decisive legal protection against discrimination when seeking employment or housing. At a time when so few Americans choose to serve in the military, some veterans may face discrimination as a result of either their perceived future military obligations or negative stereotypes associated with military service. This bill seeks to align veterans' status with other protected groups who have faced discrimination in the workplace or in acquiring housing. Veterans should not be shut out of quality careers or denied a lease because of their current or past military service. This legislation seeks to ensure that it never happens again.

S. 1295, A BILL TO AMEND TITLE 38, TO REQUIRE THE SECRETARY OF VA TO PROVIDE VETERANS WITH NOTICE, WHEN VETERANS ELECTRONICALLY FILE CLAIMS FOR BENEFITS UNDER LAWS ADMINISTERED BY THE SECRETARY, THAT RELEVANT SERVICES MAY BE AVAILABLE FROM VETERANS SERVICE ORGANIZATIONS.

The VFW supports the intent of this legislation, which would codify much of what VA is currently doing to make veterans aware of the services veterans service organizations (VSO) can provide when filing of claims for disabilities. Currently, on VA's "benefits description" page of its Web site, there is a link to request assistance from or search a list of VSOs that can provide assistance. There is similar information found once veterans logon to eBenefits.

The only additional measure this legislation provides is direct notification to veterans when they begin the application process. The VFW would support an added step, in the form of a pop-up, which would direct the applicant to the claims assistance information page VA already has established when applying for benefits online.

S. 1399, SERVICEMEMBER STUDENT LOAN AFFORDABILITY ACT

The VFW fully supports Senator Durbin's bill which extends SCRA protections to servicemembers seeking to refinance or consolidate pre-service Federal or private student loans. Currently, servicemembers that opened student loans prior to military service that choose to participate in the Federal Public Service Loan Forgiveness program (PSLF) lose the six percent loan rate cap afforded to them by SCRA. This legislation corrects this loophole and extends the option of PSLF to servicemembers without forcing them to lose their six percent loan rate cap. Additionally this legislation protects servicemembers seeking to refinance student loans through debt consolidation from losing their six percent loan rate caps. As student debt is on the rise, now second only to mortgages, programs such as (PSLF) and debt consolidation are both practical and effective ways to manage student loan debt.

S. 1411, RURAL VETERANS HEALTH CARE IMPROVEMENT ACT OF 2013

VA will be reporting its findings of rural health care gaps through its Strategic Plan Refresh for Fiscal Years 2012 through 2014 VA Office of Rural Health. This legislation would define some of the data points VA must report and use to determine their performance and accountability goals. These data collection points would include recruitment and retention of health care providers, timeliness and quality of care by VHA and through contract and fee-based care, and the implementation, expansion of telemedicine. VA would also be required to describe its procedures for assessing each rural Department facility.

It is apparent that a wide gap exists between rural veterans and their urban counterparts in the ability to access their earned VA health benefits. With 41 percent of all VA enrollees residing in rural areas, the VFW believes that this access gap must be closed, but the situation is not without significant challenges. While roughly 25 percent of the U.S. population lives in rural areas, only 10 percent of physicians practice in those communities. This highlights the need for VA to proactively recruit and retain them in rural facilities. Of highly rural veterans, 64

percent must travel more than four hours to receive specialty care, emphasizing the need for VA to continue to expand telehealth services. By addressing these and other issues, the VFW believes that this legislation represents a positive step toward solving the unique problems faced by rural veterans.

S. 1471, ALICIA DAWN KOEHL RESPECT FOR NATIONAL CEMETERIES ACT

This act would codify the authority of the Secretaries of Veterans Affairs and Defense to reconsider prior decisions of interments in national cemeteries. Title 38, U.S.C. outlines crimes that disqualify veterans from interment in national cemeteries, but there are no provisions for the removal of a veteran who was laid to rest in a national cemetery prior to the discovery that he or she had committed a disqualifying crime.

This legislation also calls for the disinterment of a specific veteran who committed murder, and then turned the gun on himself, ending his life. He was buried in a national veterans cemetery six days later. The circumstances of this case made it very difficult for VA to discover the murder that would have precluded this veteran from interment.

The VFW supports this legislation, but believes it falls short in preventing future non-qualifying interments from taking place. Current protocol requires the surviving family member to fax qualifying paperwork—DD214 and death certificate—to the National Cemetery Administration (NCA). Upon receipt of these documents, NCA calls the family member and asks 16 questions. These questions range from location of death and burial needs to cemetery choice and marital status. Nowhere in the questioning does NCA ask a question regarding criminal activity. The requesting family member should be required to fill out a form that asks the current 16 questions and an additional question regarding Federal or state capital crimes. Knowing this information will assist NCA in investigating disqualifying crimes, prior to the veteran's interment.

S. 1540, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO INCLUDE CONTRACTS AND GRANTS FOR RESIDENTIAL CARE FOR VETERANS IN THE EXCEPTION TO THE REQUIREMENT THAT THE FEDERAL GOVERNMENT RECOVER A PORTION OF THE VALUE OF CERTAIN PROJECTS.

The VFW supports this legislation which would allow state veterans homes that receive residential care contracts or grants from VA to also contract with VA under the Health Care for Homeless Veterans (HCHV) supported housing program. Since state veterans homes receive VA funding for other programs, the recapture clause of section 8136 of title 38 prohibits them from receiving HCHV funds. Only those state veterans homes that also run outpatient VA clinics are currently exempted from the recapture clause. This means that many state veterans homes with empty beds are unable to offer them to homeless veterans in their communities. Similarly exempting them from the recapture clause would solve this problem.

The Secretary's ambitious five year plan to end homelessness among veterans includes six strategic pillars. The sixth pillar is community partnerships, which certainly must include state veterans homes. The VFW strongly supports the Secretary's five year plan and believes that state veterans homes should be utilized to the fullest extent possible to ensure its success. As long as there are homeless veterans who need them, beds in state veterans homes should not remain empty simply due to the unintended consequences of a Federal regulation.

S. 1558, VETERANS OUTREACH ENHANCEMENT ACT OF 2013

The purpose of this legislation is to enact a five-year program aimed to increase awareness and access of Federal, state and local veterans programs for service-members and veterans. In doing so, VA could enter into agreements with Federal and state agencies and provide technical assistance, award grants for projects and activities that would build awareness and usage of programs and services provided at all levels of government and within the nonprofit sector.

The VFW supports this legislation.

S. 1573, A BILL TO PROVIDE PAYMENTS OF TEMPORARY COMPENSATION TO SURVIVING SPOUSES OF VETERANS UPON THE DEATH OF THE VETERAN.

This legislation would provide six months of temporary payments of Dependency and Indemnity Compensation (DIC) or Pension for surviving spouses of veterans if, at the time of death of the veteran, the veteran was in receipt of or entitled to receive (or but for the receipt of retired or retirement pay was entitled to receive) compensation for a service-connected disability continuously rated as total for not less

than one year immediately preceding the death of the veteran, or if the veteran was in receipt of pension under section 1513 or 1521 of title 38 as a married veteran based on the marriage of the veteran to the individual.

The VFW supports the intent of these provisions as a stop-gap measure for surviving spouses during their time of greatest need. However, as the bill is written, the benefit would be paid regardless of whether or not the surviving spouse ever submits a claim for the benefit. The VFW recommends that at minimum of a certificate of death must be provided to VA by the surviving spouse, to act as an informal claim before temporary payments begin must be submitted to VA. This will protect the integrity of the program, but allow payments to be made while the claim is developed and approved.

A DRAFT BILL TO AMEND TITLE 38, UNITED STATES CODE, TO PROVIDE REPLACEMENT AUTOMOBILES FOR CERTAIN DISABLED VETERANS AND MEMBERS OF THE ARMED FORCES, AND FOR OTHER PURPOSES.

The VFW supports this legislation which would allow VA to replace a vehicle provided to a veteran under the Automobile Grant Program twice, with the aggregate amount of the original and replacement vehicles not to exceed the maximum amount allowable under the program. Further, it increases the maximum amount from \$18,900 to \$30,000 and authorizes VA to replace vehicles provided under the program that are destroyed by natural disasters or other circumstances in which the veteran is found to be not at fault.

Currently, the VA automobile grant is a one-time benefit. Veterans may use the grant only once in their lifetimes, regardless of whether they purchased a vehicle for less than the full amount allowable under the law, or if that amount is ever increased. The VFW believes that eligible veterans should be able to receive additional grants if the grant amount for the initial vehicle was less than the maximum. This legislation achieves that goal, providing greater spending flexibility for eligible veterans and ensuring that they are able to make full use of the benefit.

VA automobile grants are provided only to the most severely disabled veterans who may require vehicles with specific accommodations. The original intent of the grant when it was established in 1946 in the amount of \$1,600 was to cover 100 percent of the cost of a new vehicle. According to the Department of Transportation, the average costs of a modified vehicle today range from \$40,000 to \$65,000 new and \$21,000 to \$35,000 used. Although the current automobile grant amount of \$18,900 is useful to veterans as a means of cost abatement, it does not come close to covering the full purchase price. Clearly the grant has not been sufficiently increased over time, relative to inflation. Increasing the amount to \$30,000 would represent a big step toward ensuring that severely disabled veterans are able to afford the specialized vehicles they need.

DRAFT BILL, VETERANS HEALTH CARE ELIGIBILITY EXPANSION AND
ENHANCEMENT ACT OF 2013

This legislation calls for extraordinary changes to the Veterans Health Administration by providing for the largest enrolment eligibility expansion in over a decade. The VFW supports the intent of this legislation, however, we would like to offer certain caveats and recommend several changes before we are able to offer our full endorsement.

Section 3 would greatly expand VA patient enrolment by extending eligibility to veterans with non-compensable service-connected disabilities rated as zero percent disabling and those without service-connected disabilities who are not currently able to enroll, so long as they do not have access to health insurance, except through a health exchange established by the Patient Protection and Affordable Care Act.

The VFW supports the spirit of this section, as it would provide an increased number of honorably discharged veterans with access to quality health care who may not otherwise have that opportunity. We are concerned, however, that a large influx of new enrollees could overcrowd the system, exacerbating already unacceptably long wait times. In order to prevent this, VA would presumably need to expand its capacity by hiring additional employees and constructing or leasing new facilities. This would require either a significant funding increase, or the redirection of funding from other areas of the VA budget which the VFW could never support. With no discernible offset, we feel that there is some cause for trepidation. As a result, we must state that the VFW would only support the eligibility expansion called for by section 3 if VA is provided the additional funding necessary to carry it out, without compromising current quality or access standards, or in any way diminishing the programs and services provided to those already enrolled. It is important that the care provided of veterans who are service-connected or have finical need

is not disrupted or diminished in any way. Also, with rapid expiation a plan must be put in place to account for the capacity issues that will arise. The VFW looks forward to working with the Committee on solving these issues.

Section 4 would further extend the period of eligibility for health care benefits for veterans of combat during certain periods of hostilities and war. Eligibility for Iraq and Afghanistan veterans would be extended from five to ten years following separation from service, and eligibility for veterans of post-Gulf War hostilities prior to January 28, 2003 would be extended until January 28, 2018. The VFW fully supports this section.

Section 6 would simplify the method VA uses to determine which veterans qualify for enrolment as members of low income families. Currently, each county has its own geographically based income threshold. This section would mandate that the highest income threshold among the counties of each state become the income threshold of the entire state. This would qualify many veterans for enrolment who are currently ineligible but whose income level is relatively close to the geographic means test threshold. The VFW supports this eligibility expansion, but only if VA is provided with adequate funding to ensure that access or services are not diminished for current enrollees.

DRAFT BILL, ENHANCED DENTAL CARE FOR VETERANS ACT OF 2013

This legislation contains several provisions relating to non-service-connected dental services, most of which the VFW supports.

Section 2 would authorize VA to provide restorative non-service-connected dental services, including necessary dental appliances, to certain veterans. Currently, VA may provide those services to any veteran receiving hospital care or nursing home care in a VA facility if the non-service-connected dental condition is associated with or aggravating a disability for which the veteran is receiving hospital care, or if VA determines that a dental emergency is present during hospitalization. This legislation would allow VA to also furnish dental services to restore functionality that has been lost as the result of any services or treatment received while under hospital or nursing home care. The VFW supports this common sense fix.

Section 3 would establish a three-year pilot program at no less than 16 locations to provide dental services to any veteran commensurate with the dental services furnished to 100 percent service-connected veterans. VA would be authorized to enter into contracts as necessary and copayments would be collected. The amount expended on each veteran per year would be capped at \$1,000 or a greater amount, as determined by VA.

VA is already set to roll out a three year pilot program to offer affordable dental insurance to all enrolled veterans and CHAMPVA beneficiaries known as the VA Dental Insurance Program (VADIP). Created by the Caregivers and Omnibus Health Services Act of 2010, VADIP will offer a wide array of dental plans to those veterans and eligible dependents through the Delta Dental and MetLife insurance companies at reduced rates, with care available nationwide and monthly premiums starting as low as \$8.65. While the VFW is not fundamentally opposed to the program model offered by section 3, we are supportive of VADIP and believe that it should function for the duration it has been authorized and evaluated for effectiveness and veteran satisfaction before another program which offers duplicative services, as outlined by this section, is piloted.

Section 4 would require VA to carry out a program of education to promote veterans' dental health. This would be achieved by distributing literature at VA facilities, publishing information on the VA Web site, and conducting small and large group presentations. The VFW supports this section.

Section 5 would require VA to establish a mechanism by which private sector providers would be able to share information on dental care furnished under VADIP with VA for the inclusion of that information in the veteran's electronic health record. This information would only be shared at the election of the veteran and VA would be authorized to extend VADIP an additional two years if the Secretary determines it necessary to assess the information sharing mechanism. The VFW supports this section, strongly believing that VA must be responsible for ensuring proper coordination and continuity of care for all non-VA services provided under any Department program.

DRAFT BILL, MENTAL HEALTH SUPPORT FOR VETERAN FAMILIES AND CAREGIVERS ACT OF 2013

The VFW supports this legislation which would establish an education program and peer support program for family members and caregivers of veterans with mental health disorders. To carry out these programs, VA would contract with non-profit

entities with experience in mental health education. The education program would consist of instruction on types of mental health disorders, techniques for handling crisis situations, coping with stress, and additional services. Those who graduate the education program may be selected to act as a peer support coordinator, who would then lead group meetings with other family members and caregivers to assist them with matters related to coping with mental health disorders in veterans. These programs would initially be offered at 30 VA facilities, and the Secretary would be required to report on the feasibility and advisability of continuing and expanding the program after one year.

Mental health disorders among veterans often affect family members, placing great strain on family relationships and ultimately exacerbating the veteran's condition. If properly trained, however, family members can have a positive impact on the veteran's recovery. The VFW supports promoting family engagement as an important part of mental health treatment.

DRAFT BILL, MEDICAL FOSTER HOMES ACT OF 2013

The VFW supports the intent of this legislation which will allow VA to cover the costs associated with the care of eligible veterans who require a protracted period of nursing home care and desire to live in medical foster homes. VA currently has the authority to reimburse institutional care facilities such as nursing homes for long-term domiciliary care, but veterans who choose to live in medical foster homes must do so at their own expense. Granting VA the authority to reimburse medical foster homes would provide veterans with an additional residency choice, potentially improving the quality of life for those who would prefer to live in a family style setting rather than an institutional one. The VFW recommends, however, that this be achieved by amending section 1720 of title 38, United States Code, rather than instructing the Secretary on how to carry out section 17.73 of title 38, Code of Federal Regulations. We feel that codifying this new benefit would reduce any chance of bureaucratic misinterpretation and ensure that it is not arbitrarily eliminated or diminished in the future.

Furthermore, the VFW strongly believes that all non-VA services should be provided in conjunction with proper care coordination. VA Handbook 1141.02, Medical Foster Home Procedures, establishes the policies and standards of VA care coordination for veterans who choose to live in medical foster home settings. It requires an interdisciplinary VA Home Care Team to provide the veteran with primary care, regularly communicate with the foster home caregiver, and monitor the care provided by the foster home with frequent unannounced visits. The VFW feels that these requirements will continue to be instrumental in ensuring adequate care coordination for veterans who chose to participate in a fully-funded medical foster care program. VA Handbook 1411.02 is scheduled for recertification in 2014, and the VFW recommends that the care coordination policies outlined in that document be made permanent by adding them to the language of this legislation.

DRAFT BILL, SCRA ENHANCEMENT AND IMPROVEMENT ACT OF 2013

The VFW supports Chairman Sanders and Senator Rockefeller in their efforts to improve the Servicemembers Civil Relief Act (SCRA). SCRA exists to offer a wide range of protections to individuals entering active duty, as well as servicemembers activated from the Reserve Component. SCRA ensures servicemembers are able to fully devote their attention to duty and seeks to assuage additional stress often placed on family members of those in service. We believe many of the provisions found in this bill offer substantial improvements to SCRA's current framework as they provide much-needed expansions to the bill's depth, reach, and enforcement. For example, the VFW fully supports offering an additional year of SCRA protection to ensure transitioning servicemembers can organize their affairs, and we also support policies that will ensure servicemembers cannot be denied credit because of their military service.

The VFW applauds Chairman Sanders and Senator Rockefeller for each taking the issue of protecting servicemembers and their families very seriously. We are pleased that this bill offers unique solutions to improve the many current issues related to SCRA. However, we have several questions about the provisions in this draft of the legislation related to servicemembers' business properties and loans on which servicemembers serve as the guarantor or co-signor. We look forward to discussing these issues with committee and developing a quality bill that protects the financial and legal interests of our servicemembers.

Moreover, the VFW believes that more understanding on SCRA is needed, which is why we recommend a possible stand-alone hearing on SCRA in the coming year. Make no mistake, SCRA is substantially beneficial to servicemembers, but we con-

stantly hear stories of how many still fall through the cracks. The VFW asks the Committee to take an in-depth look at the financial and legal needs of our servicemembers, solicit feedback from all relevant stakeholders, and develop comprehensive legislation that seeks to address many of the persistent shortfalls we often find in SCRA. We look forward to working with the Committee to develop a comprehensive reform package that meets the needs of today's servicemembers by protecting their financial and legal interests.

DRAFT BILL, SURVIVORS OF MILITARY SEXUAL ASSAULT AND DOMESTIC ABUSE
ACT OF 2013

The VFW does not support section 2 of this legislation which would authorize VA to provide counseling services to active duty servicemembers for the treatment of psychological trauma associated military sexual assault without obtaining referrals from their military primary care providers. While we recognize the need to support victims of military sexual assault in every reasonable way possible, we firmly believe that any counseling or treatment should be provided at Department of Defense facilities in order to ensure proper coordination of care and appropriate chain-of-command involvement. Commanders are ultimately responsible for the health and well-being of their subordinates and it is vitally important that they are aware of the mental health status of the members of their units. Furthermore, they should be informed of any criminal activity which may have taken place under their commands so that they may take appropriate action under the Uniform Code of Military Justice.

The VFW does support section 3 which would require VA to establish a screening mechanism to detect whether a veteran has been the victim of domestic abuse. In recent years, VA has been making an effort to adapt to the needs of veterans who are the victims of abuse—specifically women veterans. Domestic abuse is a particularly prevalent problem among this population, and detection is necessary to ensure they receive the proper counseling and care.

The VFW also supports section 4 which would require VA to submit reports on the treatment and prevalence of military sexual trauma and domestic abuse. The data collected will be used to improve services for the victims of those physically and psychologically devastating crimes.

DRAFT BILL TO AMEND TITLE 38, UNITED STATES CODE, TO EXPAND ELIGIBILITY FOR REIMBURSEMENT FOR EMERGENCY MEDICAL TREATMENT TO CERTAIN VETERANS THAT WERE UNABLE TO RECEIVE CARE FROM THE DEPARTMENT OF VETERANS AFFAIRS IN THE 24-MONTH PERIOD PRECEDING THE FURNISHING OF SUCH EMERGENCY TREATMENT.

The VFW supports this legislation which would authorize VA to reimburse veterans for emergent non-VA care who do not meet the requirement of having been seen at a VA facility in the preceding 24 months, simply because long wait times for initial patient examinations have prevented them from doing so. The strict 24-month requirement is especially problematic for current era veterans, many of whom have never had the opportunity to be seen at VA facilities due to long appointment wait times, despite their timely, good faith efforts to make appointments following separation. Should they experience medical emergencies during that waiting period, VA is required to deny their claims for reimbursement, unnecessarily leaving them with large medical bills through no fault of their own. VA is aware of the problem and has requested the authority to make an exception to the 24-month requirement for veterans who find themselves in this situation. The VFW supports this request, strongly believing that under no circumstances should long appointment wait times prevent a veteran from seeking emergent, possible life-saving care at a non-VA facility, or expose that veteran to financial hardship as a result of doing so.

DRAFT BILL TO AMEND TITLE 38, UNITED STATES CODE, TO REQUIRE RECIPIENTS OF PER DIEM PAYMENTS FROM THE SECRETARY OF VETERANS AFFAIRS FOR THE PROVISION OF SERVICES FOR HOMELESS FOR HOMELESS VETERANS TO COMPLY WITH CODES RELEVANT TO OPERATIONS AND LEVEL OF CARE PROVIDED, AND FOR OTHER PURPOSES.

The VFW supports this legislation which would require facilities that house homeless veterans to meet the standards of the most recently published version of the Life Safety Code of the National Fire Protection Association, as well as all relevant local building codes before receiving per diem payments under the VA Homeless Providers Grant Per Diem Program. Additionally, recipients would be inspected on an annual basis to ensure that compliance with those codes is maintained. Current per diem recipients would have two years from the time of enactment to be certified

in compliance with relevant codes before payments are terminated, giving them ample time to make any necessary improvements.

Currently, VA is required to check housing certificates before awarding grants for housing services provided to homeless veterans. However, thorough checks of fire and safety requirements, as well as structural conditions of the building, are often overlooked. The VFW believes that VA funded transitional housing must be safe, secure, and sanitary. This legislation would ensure that those standards are met, providing homeless veterans with the best chances of successful community reintegration.

Mr. Chairman, this concludes my testimony. I would be happy to take any questions you or any member of the Committee may have for the record.

PREPARED STATEMENT OF WOUNDED WARRIOR PROJECT

Chairman Sanders, Ranking Member Burr, and Members of the Committee: Thank you for inviting Wounded Warrior Project (WWP) to provide views on pending legislation. Several of the measures under consideration address issues of keen importance to wounded warriors and their family members, and we are pleased to offer our perspective.

MENTAL HEALTH

We welcome the Committee's consideration of legislation addressing key mental health issues. Long years of war have left both deep psychic scars among those who have deployed and a profound challenge for the VA health care system—to provide these veterans timely, effective mental health care. Legislation before the Committee recognizes several distinct and important mental health issues—veterans' difficulty in accessing mental health care in rural areas, the toll a warrior's distress or multiple deployments may take on the mental health of family members, and the suffering experienced by veterans traumatized by military sexual assault or domestic abuse.

As a population, wounded warriors continue to experience very high rates of PTSD, depression and other combat-related mental health conditions. A recent WWP/Westat survey of more than 26 thousand wounded warriors found that 75% of the almost 14 thousand respondents screened positive for PTSD. The survey indicates that the effects of their mental and emotional problems are even more serious than the effects of physical injuries. More than 25% reported being in poor health as a result of severe mental injuries. Our survey also found that more than one in three respondents said they had difficulty in getting mental health care, put off getting such care, or did not get needed care. About 40% said one of the difficulties they had was inconsistent treatment or lapses in treatment (such as canceled appointments and switches in providers).¹

Based on the reports provided by the warriors with whom we work daily across the country, many VA facilities are still struggling to provide timely, effective mental health care. Wide gaps still exist between well-intentioned policies and on-the-ground practices. Perhaps nowhere are the challenges greater than in rural America where workforce-staffing issues and long travel distances compound the problems common to other often-overloaded VA facilities.

Congress has already set important expectations in law for VA's mental health care system. Accordingly, ongoing oversight and insistence on VA's taking further steps to close the gap between mental health policy and practice will be critical. But we appreciate the importance of closing statutory gaps and setting clear legislative markers to achieve further gains.

In that regard, we strongly support mental health provisions of the Rural Veterans Mental Health Care Improvements Act, S. 1155. We appreciate its focus on telemental health, a promising modality, whose full potential must be unlocked. In particular, we welcome provisions that would clarify a longstanding requirement in section 304 of Public Law 111-163 that the Secretary provide time-limited mental health services to family members of veterans who deployed to Iraq or Afghanistan, where such services are needed to assist in the veteran's readjustment or recovery, or the family's readjustment. Given VA's failure to implement this requirement, it is particularly important that any ambiguity in current law be erased. Our warriors' families have been profoundly affected by multiple deployments and by their warriors' struggles. Some need help themselves. With the mental health of warriors so

¹ Franklin, et al., 2013 Wounded Warrior Project Survey: Report of Findings.

inextricably connected to that of their loved ones' mental health, these needs cannot be ignored.

Given the important role of the family in supporting a warrior who is experiencing mental health problems, we welcome the Committee's consideration of S. , the Mental Health Support for Veteran Families and Caregivers Act. As an organization for which peer-mentorship and peer-support are core elements of our programming for both warriors and family members, we would support VA's fostering the development of peer-support programs for family members of veterans with mental health conditions. There are likely different models that could be mounted and evaluated. S. would direct VA to establish a two-part family support program to consist of an education segment and the establishment of peer-support groups. The bill directs that VA deploy this model over a four year period through not less than 20 medical centers, 20 clinics, and 20 Vet Centers. The measure would require that the education program be carried out over a specified period through a contract with a non-profit entity and that the program include education on different mental health conditions and techniques for handling crises and for coping with stress. VA would also be required to facilitate the establishment of a program to provide peer support to family members on coping with mental disorders in veterans, with one family member who completed the education segment to serve as a peer-support coordinator and a VA mental health provider serving as a mentor to the peer support coordinator.

While WWP applauds efforts to assist family members who are supporting veterans with mental health needs, we recommend that the measure provide for greater flexibility in program design. For example, requiring that education programs include "general education on different mental health disorders" may signal to VA that it must establish "peer" groups inclusive of the widest possible range of mental health conditions. But the families of young veterans with combat-related PTSD may not relate to the experience others have with veterans who may have very different conditions such as schizophrenia or other cognitive disorders and who may be much older. We recommend that the provision be revised to clarify that composition of peer-support groups be left to the participating family members themselves. Similarly we recommend providing somewhat greater flexibility regarding educational content so that the programs are ultimately geared to the needs of the participating families. Where, for example, the compelling need for support is among families of returning combat veterans, it would seem advisable to tailor course content to combat-stress, PTSD, and other combat-related conditions, rather than to general education on a broad range of conditions. As drafted, the bill would appear to foreclose that option.

S. , the Survivors of Military Sexual Assault and Domestic Abuse Act of 2013, would authorize the Department of Veterans Affairs to provide counseling and treatment for sexual trauma to members of the military as well as direct the Department to develop and deploy a screening tool for domestic abuse to be used when a veteran seeks VA health care services. It is certainly important, in our view, to find avenues to improve early access to counseling and treatment for those with MST-related health problems, as well as to assure the quality and effectiveness of those treatments. MST has been shown to have serious long-term adverse health implications, including PTSD, increased suicide risk, depression, and substance abuse.² Researchers report that MST is an even stronger predictor of PTSD than combat.³ With the Department of Defense reporting that 26,000 active duty servicemembers experienced a sexual assault in 2012,⁴ it is clear that there is a great need for resources, support, and effective treatment for those who are coping with health issues as a result of an in-service assault.

However the scope of the problem is not limited to access to care. Testimony at a recent House Veterans' Affairs Health Subcommittee hearing provided strong evidence that both the Department of Defense and the VA are failing to provide adequate mental health services for veterans who had been raped by fellow servicemen. Veterans at that hearing detailed very troubling, yet similar experiences relating not only to access to VA care, but to inadequate screening, providers who were either insensitive or lacked needed expertise, and facilities ill-equipped to care appropriately for MST survivors.⁵

²M. Murdoch, et al., "Women and War: What Physicians Should Know," 21(S3) J. of Gen Internal Medicine S5-S10 (2006).

³D. Yaeger, et al. "DSM-IV Diagnosed Posttraumatic Stress Disorder in Women Veterans With and Without Military Sexual Trauma," 21(S3) J. Gen Internal Medicine S65-S69 (2006)

⁴<http://www.defense.gov/transcripts/transcript.aspx?transcriptid=5233>

⁵<http://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=101095>

WWP does see value in authorizing access to VA mental health care to active duty members who experience a military sexual assault, especially given the strong disincentives for victims either to report or seek needed treatment within the Department of Defense.⁶ However, we have concerns about the VA's capacity to provide such care, given continued serious gaps in timeliness and effectiveness of its provision of mental health care to veterans, as reflected in the recent House hearing and as we have highlighted in previous testimony. With those concerns, we urge the Committee to pursue these issues through oversight, to include conducting a searching inquiry as to whether VA has yet achieved the level of mental health staffing needed to meet the mental health needs of our veterans. Further, we urge that such oversight focus on improving access to MST-related care and training providers, as needed, to provide effective screening and appropriate, sensitive care for those seeking treatment for MST-related conditions.

The draft bill's focus on improving VA detection of domestic abuse against veterans raises similar issues. VA's challenge in that regard may be deeper than the lack of a screening tool. Facilities that are already unable to provide timely, effective care to veterans with combat-related mental health conditions are not likely to have the requisite staffing, and may also lack the specialized expertise, to provide the complex, sophisticated care needed by a victim of domestic abuse. Again, we urge that broad oversight take precedence over charting a legislative road that may risk establishing conflicting priorities.

EMPLOYMENT

With the many bills before the Committee today, Mr. Chairman, the emphasis in our remarks on veterans' mental health reflects our view that mental health is integral to overall health, and is very much at the core of WWP's vision of fostering the most successful, well-adjusted generation of veterans in the Nation's history. Too many wounded warriors, however, have yet to regain mental health or to achieve—or mount the first critical steps toward—success.

Our most recent survey of wounded warriors should be cause for deep concern in that regard. That survey found that more than 17% of respondents are unemployed (that is, have been looking for work for an average of 26 weeks)—much higher than the 9.9% unemployment for all veterans who served since 9/11 or the 10.9% rate among those deployed to Iraq or Afghanistan.⁷ (Wounded warrior unemployment has not changed materially since our 2012 survey.) That disturbingly high rate of unemployment among those who have sacrificed so much merits close scrutiny in reviewing legislation aimed at advancing veterans' economic opportunities. It is critical, in our view, that wounded warriors are afforded the tools, skills, resources, and supports needed to develop meaningful and fulfilling careers. The goal should be economic empowerment.

Given that perspective, we welcome the Committee's consideration of S. 1262, the Veterans Conservation Corps Act, but recommend that the bill be revised. The measure would authorize appropriations to VA of \$600 million over five years to employ veterans in conservation, resource management, and historic preservation projects on public lands; in cemetery maintenance and improvement projects; and as firefighters, law enforcement officers, and disaster relief personnel, with priority to those who served on or after 9/11.

WWP welcomes in principle the bill's focus on creating new job opportunities for veterans, and the priority to be given employment for Post-9/11 veterans. But with its job targets seemingly limited to manual labor or work as first-responders, warriors whose severe disabilities have already contributed to unemployment may find few opportunities. We urge that the Committee further develop this bill, and—particularly for wounded warriors—place greater emphasis on career-building employment opportunities and on creating avenues to a broader range of positions better suited to veterans whose disabilities might rule out employment doing manual labor or as first-responders.

Given the importance of creating new opportunities for wounded warriors that can lead to the development of new skills and career-building employment opportunities, WWP also welcomes the Committee's consideration of S. 1216, the Improving Job Opportunities for Veterans Act of 2013. The central provision of that bill would require VA to enter into agreements with the heads of other Federal departments and agencies to operate on-the-job training programs to train eligible veterans to perform skills necessary for employment by the department or agency operating the

⁶R. Kimerling, et al., "The Veterans Administration and Military Sexual Trauma," 97(12) *Am. J. of Public Health* 2163 (2007).

⁷Franklin, 71.

program. Such programs hold promise and merit development. We recommend, however, that the measure be amended to establish a priority for service-disabled veterans in instances where veterans' preference laws would not otherwise apply.

HEARING LOSS AND TINNITUS

This Committee knows well that blast injuries in Iraq and Afghanistan have left thousands of our warriors with severe polytraumatic injuries. Those blasts have, of course, left many more with debilitating invisible wounds, including severe hearing loss and tinnitus. WWP's most recent survey of wounded warriors (with responses from 52% of the almost 27 thousand whom we surveyed) illustrates the prevalence of hearing impairment in this population. Almost 58% of respondents sustained injuries as a result of blasts (including IED's, mortars, and grenades).⁸ Not surprisingly then, more than 52% experience tinnitus⁹ and 17.5% severe hearing loss.¹⁰ Overall, more than half of all our respondents reported that their health is fair or poor. But more than 60% of those with severe hearing loss described themselves as being in only fair or poor health; of those with tinnitus, 57% reported being in fair or poor health.

Transition to civilian life and financial issues remain keen concerns for our warriors,¹¹ and VA benefits are necessarily vitally important to their financial well-being. Yet in our recent survey, 42.5% of warriors with severe hearing loss and 41.8% of those with tinnitus reported that their financial status is worse than a year ago.¹² Most VA hearing loss claims are adjudicated at 0% disabling, and VA deems recurrent tinnitus to be only 10% disabling.¹³ Such marginal compensation would seem to suggest that hearing impairment and tinnitus cause only minimal impairment and have little to no effect on average earning capacity. Veterans who live daily with hearing loss and ringing in their ears would disabuse this Committee of any such thought. Indeed VBA-convened medical experts have advised the Department that its rating and testing criteria should be fundamentally changed, and have recommended that tinnitus ratings should reflect relative level of severity, with a rating of 60% for those with severe disability.¹⁴ Those experts also faulted VA for evaluating hearing loss in noise-free settings (in 93% of cases); such testing fails to account for the loss of acuity and clarity that a hearing-impaired individual experiences in the noisy, "real-world" settings where veterans work and live.¹⁵

The Department of Veterans Affairs is responsible in law not simply to adjudicate claims for service-incurred disability, but also to update periodically the criteria for rating those disabilities as well as to employ the most reliable clinical and technological means to evaluate disability. While the Department has testified repeatedly to the challenges it faces in its efforts to eliminate a deep backlog of claims, it has been less forthcoming about the very limited progress made to date in its long-ongoing effort to revise its rating criteria. Revisions to the rating criteria for evaluating hearing impairment and tinnitus are long overdue.

Mr. Chairman, we appreciate your work in crafting legislation aimed at improving compensation for hearing loss. That legislation does raise concerns, however. First, with VBA having already devoted several years to reviewing these rating criteria, directing the Department to report—conceivably two years from now—on issues regarding its hearing-loss rating criteria could have the unintended effect of VA's further deferring by several more years the development of these long-overdue changes to the rating schedule. Second, insofar as the legislation includes no reporting requirements specific to tinnitus, it could be misconstrued to signal that the criteria for rating that condition are not in question.

To the contrary, those who live with tinnitus would be quick to explain that it is not a trivial or minimal annoyance. For many, the condition interferes with sleep, hearing, concentration, thinking, and emotional well-being. As discussed at a VA-sponsored VASRD forum on audiology, surveys of people who suffer from blindness, loss of hearing and severe tinnitus rated tinnitus as the most disabling.¹⁶ How then does one explain rating criteria that assign only a 10% rating for this condition? It

⁸Id., 19.

⁹Id., 18.

¹⁰Id., 19.

¹¹Franklin, 121.

¹²Id., 97.

¹³B. Flohr and K. Dennis, "Compensation and Pension Workshop," Academy of Federal Audiologists and Speech Language Pathologists Conference, accessed at http://www.afaslp.org/AVAA%20conferences/Dennis&Flohr2009_CP.pdf

¹⁴"VA Schedule for Rating Disabilities (VASRD) Improvement Forum: Updating the VA's Disability Evaluation Criteria" (New York City), October 11, 2011.

¹⁵Id.

¹⁶Id.

would appear that VBA has capped the rating at 10% based on a characterization of tinnitus' impairment as "subjective" in nature. (Reviewing a decision point in the history of tinnitus compensation, a VBA official explained that "Because it remained a subjective condition, the 10% limitation on disability was continued.")¹⁷ Yet the rating schedule is fundamentally inconsistent in that regard. Medical science lacks objective tools to measure the degree of impairment caused by mental health conditions, for example; yet the VA rating schedule, however flawed in that regard, certainly recognizes that mental illnesses can be totally disabling.

In short, whether the Committee proceeds legislatively or through oversight, we ask that you press for timely VA adoption of sound criteria for rating both tinnitus and hearing loss.

AUTOMOBILE ALLOWANCE

Just as compensation is critical to a wounded warrior's rebuilding his or her life, having the mobility provided by an automobile or other conveyance is often integral to a profoundly disabled individual's combatting isolation and achieving maximum independence in the community. With that perspective, we greatly appreciate the development of draft legislation to improve the current automobile allowance benefit. Your proposal, Mr. Chairman, would change the benefit from the current one-time allowance to one that would permit an eligible veteran to use the allowance to obtain two replacement vehicles, up to an aggregate cap of \$30,000, as adjusted annually by the consumer price index. This represents a very important change—not only in its recognition of the finite lifetime of even a very well-maintained vehicle,¹⁸ but of the changing vehicular needs many young warriors will experience as they start and grow families in the years ahead. We appreciate the wisdom underlying this measure, and pledge our strong support.

DENTAL CARE

In closing, we note that the Committee has before it a number of bills that reflect recognition of gaps in current law or in VA programs. Some of those gaps are more obvious than others. In that regard, S. _____, the Enhanced Dental Care for Veterans Act of 2013, addresses what is clearly the limited scope of VA dental coverage. In general (and with very limited exceptions), current law limits VA to dental treatment of service-connected dental conditions or to coverage for veterans who have a 100% service-connected rating. Among its provisions, the bill would direct VA to carry out a pilot program at a limited number of facilities through which enrolled veterans could be afforded needed dental care up to a dollar amount of not less than \$1,000. This measure's underlying concern—that the scope of VA dental coverage is unreasonably narrow—is sound. Especially troubling but much less apparent, however, is that—with VA's longstanding claims backlog—combat-injured veterans who should be afforded timely dental treatment under existing law have been denied urgently needed VA dental treatment because dental trauma had not yet been adjudicated service-connected. To cite a specific case, it is untenable that a veteran who in combat sustained head injuries with accompanying severe dental trauma (circumstances explicitly covered under section 1712(a)(1)(C) of title 38, U.S. Code), should have his need for dental treatment deferred for an indefinite period pending a formal adjudication of service-incurrence. Undoubtedly, the draftsman of this longstanding authorization of VA dental care for service-connected dental trauma would never have foreseen adjudication backlogs of the dimensions our warriors face today. We urge that the Committee at its next markup amend section 1712 to ensure that needed dental care to repair damage caused by combat trauma is treated promptly, without any requirement for formal adjudication of service-connection.

Thank you for your consideration of our views. We would welcome the opportunity to work with the Committee to address further the important matters discussed in this statement.



¹⁷B. Flohr and K. Dennis, *supra*.

¹⁸See Polk survey, accessed at Forbes (<http://www.forbes.com/sites/jimgorzelany/2013/03/14/cars-that-can-last-for-250000-miles/>).